COMMUNITY ENGAGEMENT PROJECT
The NIMHE Mental Health Programme

REPORT OF THE COMMUNITY LED RESEARCH PROJECT
FOCUSING ON MENTAL HEALTH NEEDS OF EASTERN EUROPEANS AND PREPAREDNESS OF SERVICES TO MEET THIS NEED

CARRIED OUT BY RETHINK, WEST DORSET SERVICES

“You sort of know that you don't exist somehow.”

Report by Andrew Court

West Dorset Rethink Research Team

Andrew Court
Ruth Brown
Joseph Olubodun
Said Lakehal

March 2008
Funded by C.S.I.P.
Managed and supported by

The Centre of Ethnicity and Health, University of Central Lancashire

Care Services Improvement Partnership  

Dorset Primary Care Trust
THE PROJECT TEAM

The following are members of the project team:

Andrew Court, 41, has been the Operations Team Leader for Weymouth and Portland Rethink Community Services for 5 years. In this role he has been Diversity and Equality Lead for Dorset for the last 3 years. This role has been interesting and challenging and led to the desire to complete a project such as this.

Ruth Brown, 27, Community Development Worker for Black and Ethnic Minorities (Mental Health) at Dorset Primary Care Trust. Ruth has been supporting the Delivering Race Equality agenda across Dorset and so has been keen to be involved in the research project to increase the engagement with local BME communities.

Saïd Lakehal, of French /Algerian origin, moved to Dorset at the end of 2006 following 10 years working in London and Cheltenham. Prior to that, he was an entrepreneur in a successful family business in Chalon S/Saone, France. He has a strong interest in diversifying his skills and also wanted a change of direction for his career. Saïd has since taken up several RLN sponsored opportunities, and has since taken on several students for private tuition and is applying to be a CDW for Black and Minority Ethnic Communities.

Joseph Olubodun, age 45. I was born in Nigeria and came to England age 6, to join my parents. I study at the London College of Fashion and ran my own business for around 12 years, before giving this up to pursue another career. I trained in counselling and the worked voluntary for a number of agencies.
ACKNOWLEDGEMENTS

Thank you firstly to all the people who agreed to take part in this study, people from the local Eastern European community and staff from the local mental health services. Thanks to the Department of Health and Care Services Improvement Partnership for funding this research project. Thank you to Joanna Hicks and the training and support teams from University of Central Lancashire (Uclan). Thank you to the project steering group members who are all named below and organisations for their time, support and guidance:

Sue Bickle South West Dorset Multicultural Network
Jane Brennan Dorset Primary Care Trust
Genevieve Gallagher Dorset Primary Care Trust
Caroline Gamble Rethink
Glen Gocoul Dorset County Council
Joanna Hicks Uclan
Irfan Mohammed Dorset Primary Care Trust
Miriam Morgan CSIP
Mark Patterson CSIP
Chris Ricketts Dorset Primary Care Trust

Also the team would like to thank and acknowledge the help and advice from various local organisations including:

Dorset Primary Care Trust
Dorset County Council
Dorset Police Force
Dorset Schools
Ethnic Minorities Achievement Service (EMAS)
North Dorset Citizens Advice Bureaux (CAB)
Rafal Skarbek and the Somerset Polish Community Association
Smart Recruitment
Weymouth and Portland Borough Council

The many and various contacts that helped during this study.
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1. EXECUTIVE SUMMARY

This project details the findings of a community engagement research project conducted by Weymouth Rethink, in association with Dorset Primary Care Trust (PCT). The project has been funded by the National Institute for Mental Health in England (NIMHE) and has been managed and supported by the University of Central Lancashire (Uclan).

The project was undertaken as part of an England-wide programme in which 80 community groups explored salient issues within their communities associated with mental health needs, provision and services for people form black and ethnic minorities (BME). The brief included those from Eastern European backgrounds.

All of the community engagement projects exploring these mental health issues were designed to tie in closely with the Government’s 2005 Delivering Race Equality in Mental Health Care agenda (DRE).

Dorset has traditionally attracted relatively low numbers of people from BME backgrounds, but it was observed that during the last few years, this picture has rapidly and dramatically changed with the arrival in the County of a new population of migrant workers.

The project team were interested in exploring the experiences of the new arrivals in terms of their mental health needs and state of readiness of local services to cater for any current and future need.

The project took place between May 2007 and April 2008. The fieldwork took place in January 2008 and analysis of data and writing of the report in February to April 2008.

1.2 Aims and objectives

This research project aimed to identify the mental health needs of Eastern Europeans from the A8 Accession countries living and working in North, West and South Dorset. In parallel to this the mental health service providers would be researched on the preparedness to meet this need.

The aims of the project also contributed towards exploring these themes which are embedded in the Delivering Race Equality national programme:

- Less fear of mental health care and services among BME communities and BME service users
- Increased satisfaction with services
- A more active role for BME communities and BME service users in the training of professionals, in development of mental health policy, and in the planning and provision of services
- A workforce and organisation capable of delivering appropriate and responsive mental services to BME communities
The objectives of Weymouth Rethink research project were:

- To develop and engage with the BME communities
- To investigate the availability of mental health services for BME communities
- To identify statutory services that are available to BME communities and to find out the potential barriers of BME communities to accessing mental health services in order to identify service gaps
- To increase the knowledge and awareness of mental health services
- To highlight the awareness of mental health issues in the community

1.3 Methodology

A qualitative research design was selected in order to gather rich and detailed experiences. However, some quantitative data was gathered to give basic demographic profile of respondents, and this was collected as part of the required Uclan core data.

An initial target of conducting 4 focus groups was set, and via these it was expected to conduct in depth qualitative research with 30 people from the A8 accession countries. However, as is explained within the body of this report, the sample achieved was significantly lower than initially expected due to a variety of unavoidable factors.

In the final analysis a total of 3 focus groups were conducted, plus one in-depth interview, with total number of respondents form the community being 8.

In addition in-depth interviews were held with 7 Community Mental Health Team Managers across the County.

1.4 The research team

A team of four worked on the project, including a Mental Health Community Development Worker.

1.5 Steering Group

A multi-agency steering group was formed to guide the project and offer advice. The Group met monthly throughout the life of the project.

1.6 The findings and observations- focus groups

Arrival in the UK:
It was found that the time shortly after arrival in the UK is, not unsurprisingly, probably the most stressful for migrant workers. Not only are cultural and change issues apparent, but language issues are also acute. Even for those who already speak good English, there is a ‘settling in’ period whilst becoming accustomed to local accents and everyday ‘non-textbook’ English
Many participants expressed the feeling of alienation, of not belonging. This along with isolation could cause, at the minimum apprehension, and perhaps major stress which could lead to depression.

**Knowledge of services and seeking help:**
GP’s were well-acknowledged as the first port of call when feeling unwell, though participants tended to associate visiting a GP more with physical symptoms, rather than mental conditions.

However, experiences at the GP’s surgery were mixed and some voiced concerns about not being listened to and not being satisfied with prescriptions/treatment given.

**Stigma of mental health illness:**
Participants reported a high level of stigma around mental health in their home countries.

**Cultural attitudes:**
The data shows an attitude towards not using medication unless there is no choice. Looking after their own health and being proactive with general physical issues appears important.

Participants indicated that they would seek health service support at an early stage, but not necessarily in relation to mental health problems.

**Opposition/racism:**
During the course of the project the team experienced opposition and racist attitudes from some sectors of the local community. These attitudes and associated behaviours became a barrier to conducting the research project, particularly in North Dorset.

**1.7 CMHT findings**

**Seven CHMT team leaders were interviewed regarding their services and experiences of working with people from the A8 accession countries.**

**Promotion:**
The majority of CMHT’s do not actively promote their services in the local community. Instead, referral pathways are the main source of service users. There was one exception to this, whereby a service had been highly pro-active in promoting its services in the community.

**Referral pathways:**
Most of the services report that referrals come through GP’s and self referral. Two operate an open door policy.

**Local demographic information:**
There was found to be very limited awareness among services of the changing population demographics in Dorset.
Assessment tools:
None of the services had a culturally specific assessment tool for service users from cultures other than the UK.

Currently available resources for BME service users:
Around half of the services had access to, and used, translation services. Any additional culturally specific resources were extremely limited.

Additional resources that would benefit the Eastern European community:
There were few ideas presented regarding making services more culturally appropriate in the future. It was noted that numbers coming through the system remain low.

Identifying service provision gaps:
The majority of respondents reported that they had no formal means of identifying gaps, although one said through caseload knowledge and another through team meetings and liaison with other teams. Others noted SEPIA (replacement for CPA) and analysis of raw data.

Equality and Diversity leads:
The majority of respondents reported that there was no one in the organisation in this role, though two respondents reported that their teams have a person in this role and one of these has two people sharing the role.

Equality and Diversity training:
There was evidence that the majority of the CMHT’s had personnel who had attended equality and diversity training. However, there were also reports of a perceived lack of need.

Future development plans that will ensure a responsive and appropriate service:
Just over half of respondents reported that their teams had no specific plans for future development to take BME needs into account; whilst three respondents replied that the teams to have future plans of this kind. Plans included Race Equality training, including the issue in business plan and identifying needs.

1.8 Recommendations

This section of the report will state the recommendations from the project and link them to three of the themes identified within the DRE national programme. These recommendations have been developed with caution bearing in mind the low response rate that affects the extent to which the findings of this study can be generalised:
Better collection and more effective use of information to access and target service developments:

- There is a need for the BME communities in Dorset to be accurately mapped and the information made available for a wide range of services and for this to be updated regularly. This will allow services to identify need in their community based upon the number of the target population resident there, but this can only be successful if better and more accurate recording of ethnicity is achieved allowing identification of individual ethnic groups, i.e. Polish, Slovakian rather than the broader category ‘white European’.

- Further research is required on the target community to ensure the appropriateness of assessment tools and then to develop and use an established tool across target communities that takes account of cultural differences. This research needs to identify the specific mental health needs of the Eastern European community more in depth than has been achieved in this study. Community Development Workers employed by the local Primary Care Trust would be in a position to carry out this study.

- As all services are all reliant on GP referrals, research into the referral pathways from GP’s to CMHT’s needs to be carried out and the findings acted upon. There is also a need to research the GP experience for the target group in order to create more satisfaction for the target community. Again the local Primary Care Trust Community Development Workers would be ideally positioned for this.

The development of more appropriate and responsive services for the Black and Minority Ethnic communities by statutory service providers:

- Each service and the organisation as a whole needs to develop a future strategy for developing and ensuring responsive and appropriate service for people from BME communities taking account of the local demographics and cultural and faith differences.

- Mental health services need to promote themselves, especially the self referral pathway, to the target population where they gather as a community in a way that is understandable and acceptable to BME communities. Translated leaflets and information must be made available if the services wish to offer an inclusive and accessible service. These need to be displayed and available in a number of health and community settings. There is also a need to ensure translation services are accurate and appropriate.

- All services need to adopt a formal method of identifying gaps within service provision, particularly gaps that impact on smaller communities such as BME.

- All individual services need a lead for Equality and Diversity. There also needs to be an organisational lead and structures in place to enable gathering and sharing of information, training etc.

- All individual staff should attend effective Equality and Diversity training. This could be introduced as part of the mandatory training requirement as with other organisations such as Rethink.
• Services need to prepare and gather quality resources for the target community as it is known to be the biggest and still growing BME community in the area. These would need to include quick access to quality translators and accurately translated leaflets and general mental health information relevant to the local area. Other similar areas, such as Somerset could be used to share information and become a resource.

• Cultural information training for GP’s would be an effective way of helping GP services deal with the cultural differences. To be truly effective, this will need developing and delivering with full participation and contribution from people from the local BME communities.

Community Engagement to engage communities in service development and delivery:

• A support worker to help people understand the systems used by this country and its services is essential. Preferably this would be someone of Eastern European descent or at least someone who is well versed in the cultural differences between the native English and Eastern European cultures. There is a need for a telephone support service that can deal with different languages. A community centre for the BME community is necessary so services can promote to and access the BME community.

• Services need an awareness of the stigma towards mental illness in Eastern Europe. This stigma may travel with the people that come to this country and prevent them from seeking help.

• A multi disciplinary approach needs to taken to tackle racism and to tackle the negative perceptions among the indigenous population regarding immigrant workers in Dorset.
2. INTRODUCTION

This section of the report will introduce: the Centre for Ethnicity and Health’s model of Community Engagement; the background to the work, the Key Ingredients, The Community Engagement Team, the Programme Outcomes and the focus of this report.

2.1 The Centre for Ethnicity and Health's model of Community Engagement

2.1.1 Background

We often hear the following words or phrases:

- Community Consultation
- Community Representation
- Community Involvement/Participation
- Community Empowerment
- Community Development
- Community Engagement

Sometimes they are used inter-changeably to mean the same thing. Sometimes the same word or phrase is used by different people in the same meeting to mean different things. The Centre for Ethnicity and Health has a very specific notion of Community Engagement, and this paper is an attempt to describe it. The Centre’s Model of Community Engagement evolved over a number of years as a result of its involvement in a number of projects. Perhaps the most important milestone however came in November 2000, when the Department of Health awarded a contract to what was then the Ethnicity and Health Unit at the University of Central Lancashire to administer and support a new grants initiative. The initiative aimed to get local Black and minority ethnic community groups across England to conduct their own needs assessments, in relation to drugs education, prevention, and treatment services.

The Department of Health had two key things in mind when it commissioned the work; first, the Department of Health wanted a number of reports to be produced that would highlight the drug-related needs of a range of Black and minority ethnic communities. Second, and to an extent even more important, was the process by which this was to be done. If all the Department of Health had wanted was a needs assessment and a ‘glossy report’, they could have directly commissioned a number of researchers who could have gone into local Black and minority ethnic communities, talked to them about their needs, written up a report, and produced yet another set of reports that potentially do not have any long term impact. This scheme was different however. The Department of Health was clear that it did not want researchers to go into the community, to do the work, and then to go away. It wanted local Black and minority ethnic communities to undertake the work themselves. These groups may not have known anything about drugs, or anything about undertaking a needs assessment at the start of the project; what they would have is proven access to the communities they were working with, the potential to be supported and trained and the infrastructure to conduct such a piece of work. They would be able to use the nine month process to learn about drug related issues and
about how to undertake a needs assessment. They would be able to benefit and learn from the training and support that the Ethnicity & Health Unit would provide, and they would learn from actually managing and undertaking the work. In this way, at the end of the process, there would be a number of individuals left behind in the community who would have gained from undertaking this work. They would have learned about drugs, and learned about the needs of their communities, and they would be able to continue to articulate those needs to their local service providers, and their local Drug Action Teams. It was out of this project that the Centre for Ethnicity and Health’s model of community engagement was born.

The model has since been developed and refined, and has been applied to a number of areas or domains of work. These include:

- Substance Misuse
- The Criminal Justice System
- Sexual Health
- Mental Health
- Regeneration
- Higher Education
- Asylum

New communities have also been brought into the programme: although Black and minority ethnic communities remain a focus to the work, the Centre has also worked with:

- Young people
- People with disabilities
- Service user groups
- Victims of domestic violence
- Gay, lesbian and bi-sexual people
- Women
- White deprived communities
- Rural communities

2.1.2 The key ingredients

According to the Centre for Ethnicity and Health model, a Community Engagement project must have the community at its very heart. In order to achieve this, it is essential to work through a host community organisation. This may be an existing community group, but it might also be necessary to set a real or virtual group up where one does not exist already. The key thing is that this host community organisation should have good links to the target community¹ (whoever this is) such that it is able to recruit a number of people from the target community take part in the project and to do the work (see section on task below). It is important that the host

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¹ The target community may be defined in a number of ways – in many of the Community Engagement Projects that we have run we have defined it by ethnicity. We have also worked with projects where it has been defined by some other criteria however, such as age (e.g. young people); gender (e.g. women); sexuality (e.g. gay men); service users (e.g. drug users or mental health service users); geography (e.g. within a particular ward or estate) or by some other label that people can identify with or rally around (e.g. victims of domestic violence, sex workers).
community organisation is able to provide a co-ordination and infra-structure (e.g. somewhere to meet; access to phones and computers; financial systems) for the day to day activities that will be undertaken once the project is underway. One of the first tasks that this host community organisation undertakes will be to recruit a number of people from the target community to work on the project.

The second key ingredient is the **task** that the community is to be engaged in.

Table 1. The host community organisation

<table>
<thead>
<tr>
<th>A Host Community Organisation</th>
<th>With good links to the target community</th>
<th>To provide basic infrastructure for the project (recruit and co-ordinate project team; provide office space, phones and computers; look after the finances)</th>
<th>To recruit a number of people from the target community to do the work</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Task</td>
<td>Time limited</td>
<td>A piece of research into key needs/gaps/issues for the community</td>
<td>Learning and development of key individuals; access hard to reach groups; raise awareness and debate; community ownership</td>
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<tr>
<td></td>
<td>Meaningful</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Manageable</td>
<td></td>
<td></td>
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<tr>
<td>Support</td>
<td>Financial (typically up to £20,000)</td>
<td>Training and workshops; On-going support and guidance; personal tutor</td>
<td>Statutory partnerships; steering groups; sustainability</td>
</tr>
</tbody>
</table>

According to the Centre for Ethnicity and Health model, this must be something that is meaningful, time limited and manageable. Nearly all of the community engagement projects that we have run have involved communities in undertaking a piece of research or a consultation exercise within their own communities. Sometimes we have been met with an initial resistance to doing 'yet another piece of research', but this misses the point. As in the initial programme that we ran on behalf of the Department of Health, the process (i.e. of getting ordinary people involved in doing the work) is as important, if not more important, than the report that they produce at the end of the day. The task or activity is something around which lots of other things will happen over the lifetime of the project. Individuals will learn and new partnerships will be formed. Besides, it is important not to lose sight of the fact that it will be the first time that these individuals have undertaken a research project.

The final ingredient, according to the Centre for Ethnicity and Health's model, is the provision of appropriate **support** and guidance. We do not expect community groups to become involved for nothing. Typically we would make in the region of £15-20,000 available to the host organisation. We would expect that the bulk of this money would be used to pay people from the target community as community
researchers\(^2\). We then allocate a named member of staff from our Community Engagement Team as a project support worker. This person will visit the project at least half a day once a fortnight. It is their role to support and guide the host organisation and the researchers through the project. We also provide a package of training – typically in the form of a series of accredited workshops. The accredited workshops give participants in the project a chance to gain a University qualification whilst they undertake the work. The support workers will also assist the group to pull together a steering group for the project\(^3\). The steering group is an essential element of the project: without one, it is difficult to see who the community are engaging with and it is unlikely that anything out of the project will be sustained in the longer term. The group will be doing a needs assessment or a consultation exercise, but for what purpose? It is the role of the steering group to ensure that the work that the group undertakes sits with local priorities and strategies, and that there is a mechanism for picking up the findings and recommendations that the group may make. It is also their role to help to pick up the key individuals who are developed through the project process to help them to take their ‘next steps’.

2.1.3 The Community Engagement Team

The Community Engagement Team comprises of 25 members of staff. They work across a range of Community Engagement areas of specialism, within a tight regional framework.

Table 2. The Community Engagement Team

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<thead>
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<th>National Programme Directors</th>
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<td>Northern Team</td>
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<tr>
<td>Senior Support Worker</td>
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<tr>
<td>Support Workers X 3</td>
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<table>
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<tr>
<th>Teaching And Learning Team</th>
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<tbody>
<tr>
<td>Administration Team</td>
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<tr>
<td>Communications Officer</td>
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</table>

\(^2\) This is not always possible, for example, where potential participants are in receipt of state benefits and where to receive payment would leave the participant worse off.

\(^3\) Very often we will have helped groups to do this very early on in the process at the point at which they are applying to take part in the project.
2.1.4 Programme outcomes

Each group involved in any of our Community Engagement Programmes is required to submit a report detailing the needs, issues or concerns of the community that it consulted with. The qualitative themes that emerge from the reports are often very powerful, particularly when taken together with other reports produced by groups involved in the same programme. Such information is key to commissioning and planning services for diverse and ‘hard to reach’ communities. Often new partnerships between statutory sector and hard to reach communities are formed as a direct result of community engagement projects.

The capacity building of the individuals and groups involved in the programme is often one of the key outcomes. Over 20% of those who are formally trained go on to find work in a related field.

In 2005/-6 the Substance Misuse Community Engagement Programme was externally evaluated. This concluded that:

- The Community Engagement Programme had made very significant contributions to increasing awareness of substance misuse and understanding of the substance misuse needs of the participating communities. It also raised awareness of the corresponding specialist services available and of the wider policy and strategy context.
- The Community Engagement Programme had enabled many new networks and professional relationships to be formed and that DATs appreciated the links they had made as a result of the programme (and the improvements in existing contacts) and stated their intentions to maintain those links.
- Most commissioners reported that they had gained useful information, awareness and evidence about the nature and substance misuse service needs of the participating organisations.
- All DATs reported positive change in their relationship with the community organisations. They stated that the Community Engagement Programme reports would inform their plans for the development of appropriate services in the future.
- A significant number of the links established between DATs and community organisations as part of the Community Engagement Programme were made for the first time.
- The majority of community organisations reported their influence over commissioners had improved.
- Training and access to education was successful and widely appreciated. 379 people went through an accredited University education programme.
- A third of community organisations in the first tranche reported that new services had been developed as a result of the Community Engagement Programme.
- The vast majority of participants and stakeholders expressed high levels of satisfaction with the project.

The capacity building of the individuals and groups involved in the programme is often one of the key outcomes. Over 20% of those who are formally trained go on to find work in a related field.
2.1.5 The focus of this particular report

Since 2000 over 200 community groups have taken part in one or other of the Centre for Ethnicity and Health’s Community Engagement Work Programmes.

Table 3. The National Institute of Mental Health England Community Engagement Programme.

National Institute for Mental Health in England Community Engagement Programme:

Rethink West Dorset Services was one of 80 community groups who took part in the National Institute for Mental Health in England’s Community Engagement Programme between 2005 and 2007. The objectives of the programme were to deliver and improve equality of access, experience and outcomes for Black and minority ethnic mental health service users by:

- Building capacity in the non-statutory sector
- Encouraging the engagement of Black and minority ethnic communities in the commissioning process
- Ensuring a better understanding by the statutory sector of the innovative approaches that are used in the non-statutory sector
- Involving Black and minority ethnic communities in identifying needs and in the design and delivery of more appropriate, effective and responsive services
- Ensuring greater community participation in, and ownership of, mental health services
- Allowing local populations to influence the way services are planned and delivered
- Contributing to workforce development, and specifically the recruitment of 500 Community Development Workers.

The focus of this project was to identify the mental health needs of Eastern European people living and working in North and West Dorset and Weymouth and Portland, and to evaluate service preparedness to meet these needs.

The views expressed in the report are those of the group that undertook the work, and are not necessarily those of the Centre for Ethnicity and Health at the University of Central Lancashire.

There have been a number of research projects on the Black and Minority Ethnic (BME) communities completed throughout the country but none of these had been undertaken in the particular area of Dorset that the research team are resident. West Dorset Rethink Services in partnership with Dorset PCT felt that there was a need to research the local BME communities in order to look at the issues raised by the Delivering Race Equality programme. Other issues as raised in research such as
Gemma Genco, Needs not numbers\textsuperscript{4} pointed to problems such as fear of mental health services, the stigma felt by people from a BME origin, language barriers and the lack of interpreters, racism, lack of information and understanding about mental issues and fear of being misunderstood prompted the need to study how the mental health services in North, West and South Dorset were prepared to meet the need of the local BME population. It was thought to be vital to ensure the services provided were able to offer an equitable and accessible service for all of the local community including the diverse and hard to reach BME communities.

At the time that Rethink undertook this Community Engagement Project (CEP), it was noted that there was a large increase in the number of migrant workers moving to the area particularly those from Eastern European descent. It is considered that the data regarding ethnicity within the area of research is fairly inadequate due to the diverse and transient nature of the communities, which makes it difficult for accurate mapping of the community. Although the project was unable to help with this monitoring, its aims were to help mental health services by researching people’s experiences of mental health and its effects, including perceptions of the illness and services set up to help people recover from it. As previous statistics from the Census 2001\textsuperscript{5} showed a very small number of BME people in the target area and information provided by National Insurance registrations showed a large increase in the number of incoming migrants, there was a need to find information that would help services meet the needs and access issues for the BME communities within its population.

As part of the whole national project for delivering race equality in Mental Health Care, West Dorset Rethink services aimed this research at helping to improve the quality of the services, to reduce inequalities among service users, to reduce the level of fear of mental health services in the area and to challenge the existing stigma about mental illness for future generations from BME communities.

Through this CEP, West Dorset Rethink gave the opportunity for local people from a BME background to influence local service improvement and to take part in local development of workforce and organisations.

\textsuperscript{4} Needs Not Numbers 2006, Gemma Genco
\textsuperscript{5} Census 2001, Office of National Statistics
3. AREA BACKGROUND

This section of the report will introduce the geographical area of research.

The area of Dorset covered by this project consists of the rural areas of North and West Dorset and Weymouth and Portland, in the South of the county and more urban. The 2001 Census\(^6\) results for the study area show 217,913 people living in the area of which 9,772 were born out of the United Kingdom (see appendix 1). The Registrar General's Mid-Year Home Population Estimates 2006\(^7\) (see appendix 1), show a rise of nearly 7287 people in 5 years. The three areas cover 669 square miles between them with North Dorset being the largest at 235.22 square miles and Weymouth and Portland the smallest at 16.2 square miles. These figures matched with the population figures as shown in appendix 2, show the rurality of West and North Dorset against the urban area of Weymouth and Portland.

Figure 1. Basic schematic map of Dorset and its associated districts/boroughs.\(^8\)

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\(^{6}\) Census 2001, Office of National Statistics  
\(^{7}\) Dorset Databook 2007, Dorset County Council  
\(^{8}\) Dorset Databook 2007, Dorset County Council
Immigrant workers have been living and working in the area for some time now but lately the figures for people coming from the A8 Accession Countries have risen dramatically as shown in the table below.9

Table 4. Total National Insurance Number Registrations (NINO) 2002-2007

<table>
<thead>
<tr>
<th></th>
<th>2002/03</th>
<th>2003/04</th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
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<tr>
<td>North Dorset</td>
<td>120</td>
<td>100</td>
<td>130</td>
<td>230</td>
<td>370</td>
</tr>
<tr>
<td>West Dorset</td>
<td>170</td>
<td>160</td>
<td>220</td>
<td>300</td>
<td>340</td>
</tr>
<tr>
<td>Weymouth &amp; Portland</td>
<td>90</td>
<td>80</td>
<td>160</td>
<td>280</td>
<td>310</td>
</tr>
<tr>
<td>Dorset DCC</td>
<td>620</td>
<td>590</td>
<td>830</td>
<td>1,280</td>
<td>1,650</td>
</tr>
</tbody>
</table>

9 National Insurance Number Registrations (NINO) 2007
4. AIMS AND OBJECTIVES OF THE PROJECT

This section of the report will introduce the projects aims and objectives.

An investigation into the preparedness of local mental health service provision for Eastern European communities originating from accession countries*, living or working in Dorset: a qualitative descriptive study.

*Accession countries (A8): Ten accession countries joined the European Union in May 2004. They are the Czech Republic, Cyprus, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia. Those from Malta and Cyprus were already allowed to work in the UK, hence A8, for which the rules changed in May 2004 (Dorset County Council, 2006).

4.1 Research aims

This research project conducted by Rethink West Dorset Services aims to encourage community involvement and participation by empowering local individuals, including people from BME communities, to participate in the research work. The results of this research project will contribute to the following three key aims of the Delivering Race Equality in Mental Health Care Five Year Action Plan, which is part of wider programmes on inequalities and social exclusion within the Department of Health and across government:

- Equality of Access
- Equality of Experience
- Equality of Outcomes

The aims of the project will also contribute towards exploring these themes which are embedded in the Delivering Race Equality national programme:

- Less fear of mental health care and services among BME communities and BME service users
- Increased satisfaction with services
- A more active role for BME communities and BME service users in the training of professionals, in development of mental health policy, and in the planning and provision of services
- A workforce and organisation capable of delivering appropriate and responsive mental services to BME communities

This project aims to link to the two national priorities set out below:

- The development of more appropriate and responsive services for the Black and Minority Ethnic communities by statutory service providers.
- Better collection and more effective use of information to assess and target service developments.
It also aims to help work towards the other two national priorities, which are:

- The development of a health workforce capable of working with and treating different communities.
- Better engagement of Black and minority ethnic groups in shaping mental health services and supporting innovative, community informed services.

4.2 Research objectives

The objectives of this research project are:

- To develop and engage with the BME communities
- To investigate the availability of mental health services for BME communities
- To identify statutory services that are available to BME communities and to find out the potential barriers of BME communities to accessing mental health services in order to identify service gaps
- To increase the knowledge and awareness of mental health services
- To highlight the awareness of mental health issues in the community
5. METHODOLOGY

This section of the report will introduce; the purpose of the study and rationale behind it, the literature review, how researchers were recruited, the Steering Group, the study design, ethical considerations and the limitations of the study.

5.1 Purpose of the study

This particular study will contribute to the Delivering Race Equality in Mental Health Care\textsuperscript{10} Government agenda and be part of the Community Engagement Scheme programme in conjunction with the University of Central Lancashire (UCLAN). The purpose of the study is to explore the mental health needs of migrant communities, originating from East European countries, living or working in Dorset and to investigate the preparedness of local mental health service provision.

5.2 Study rationale

Since the expansion of the European Union (EU) in May 2004, to include the Central and Eastern European Accession States (referred to as A8 states); there has been an increase in the number of migrant workers coming to the UK. Although there are no precise figures of new migrant workers in the labour force\textsuperscript{11}, the available statistics suggests that foreign nationals made up 3.5\% of the workforce in 1996, rising to 6\% in 2006\textsuperscript{12}. The recent change in trends has resulted in ethnic diversity being a significant issue in certain areas, including areas that are predominantly rural, for the first time\textsuperscript{13}.

The Delivering Race Equality in Mental Health Care action plan\textsuperscript{14} looks to achieve equality and tackle discrimination in mental health services for England for all people of Black and minority ethnic (BME) status, including those of Irish or Mediterranean origin, and east European migrants. With the total new National Insurance number registrations from overseas in Dorset steadily increasing over the last few years from 620 in 2002/03 to 1,280 in 2005/06, the accession countries accounting for almost half of the new registrations (46\%), it is an opportune time to develop the intelligence of the health care needs of these particular communities and assess whether local service provision are prepared to meet identified need.

5.3 Literature review

The number of migrants in the world has more than doubled since 1975, with most living in Europe (56 million), Asia (50 million) and Northern America (41 million).\textsuperscript{15} Migration during the 1990s was high, a period characterised by new migrations, especially from the Eastern and Central European countries (Salt, 2001) and since the expansion of the European Union (EU) in May 2004, to include the Central and Eastern European Accession States (referred to as A8 states, or accession countries), there has been an increase in the number of migrants coming to the UK, particularly to access employment. Although there are no precise figures of new

\textsuperscript{10}Department of Health, 2005
\textsuperscript{11}Health and Safety Executive, 2006
\textsuperscript{12}Audit Commission, 2007
\textsuperscript{13}Audit Commission, 2007; HSE, 2006
\textsuperscript{14}Department of Health, 2005
\textsuperscript{15}United Nations, 2002 - cited in Carta et al., 2005
migrant workers in the labour force\textsuperscript{16}, the available statistics suggests that foreign nationals made up 3.5\% of the workforce in 1996, rising to 6\% in 2006\textsuperscript{17}. The recent change in trends has resulted in ethnic diversity being a significant issue in certain areas, including areas that are predominantly rural, for the first time\textsuperscript{18}.

The growing international importance of migration has stimulated new interest in different aspects of migrant health, in addition to communicable diseases, the attention is now focused on non-infectious diseases (Uitewaal et al., 2004 - cited in Gushulak et al., 2006) and other fields including behaviour (Feng et al., 2005 - cited in Gushulak et al., 2006) and genetic or ethnic profiles (Bhopal, 2002) in migrant populations. Epidemiological studies now involve mental and psychological health (Bhugra, 2004).

A compilation of research highlights how migration affects the health, particularly the mental health, of immigrants: Carta et al., (2005) explains Puerto's (2002) description of the migratory experience being a psycho-social process of loss and change, which is known in the psychiatry of migration as a grief process. The process has been explained through a model comprised of seven grieves (losses) which are thought to cause anguish that a person will experience with time: family and friends, language, culture, homeland, loss of status, loss of contact with ethnic group, and exposure to physical risk (Achotegui, 2002 - cited in Carta et al., 2005). Carta et al., (2005) observe that difficulties in expressing grief can cause psychological problems, these difficulties being accentuated when migration is accomplished under adverse conditions. Researchers in Spain (Zapata de la Vega, 1993; Jabardo, 1993; Celaya, 1993) support Achotegui’s (2002) psycho-social process of migration adding further health affecting migration aspects, including culture and social marginalisation, family estrangement, and racial discrimination.

When looking at addressing the health needs of migrant communities it is clear that changing migration trends pose new challenges for the provision of healthcare in the UK (Hargreaves et al., 2006; Khan and Ghosh, 2005). Bhui et al., (2007) and Anderson et al., (2003) support this insight by suggesting that health professionals are now more aware of the challenges they face when providing health care to a culturally and racially diverse population. There is clearly a concern about culturally appropriate mental health care\textsuperscript{19} and it is well established that the provision of culturally competent care, practitioners having the knowledge of cultural beliefs, values and practices, is necessary otherwise healthcare workers can be at risk of making errors in diagnosis, inappropriate management and poor compliance (Dein, 2007 - cited in Bhui et al., 2007). In addition to taking cultural beliefs and values into account previous studies have indicated a further range of barriers that migrants face when seeking health care, these include access to interpreters (Burnett and Peel, 2001; British Medical Association Board of Science and Education, 2002; Papdopoulus et al., 2002 - cited in O'Donnell et al., 2006), language barriers (Bischoff et al., 2003; Gerrish et al., 2004 - cited in O'Donnell et al., 2006), and different expectations of health care (Levenson and Coker, 1999; Lipson et al., 2003; Lawrence and Kearns, 2005; Hudelson, 2005 - cited in O'Donnell, 2006). Even with these barriers identified it is still unclear whether the NHS is becoming more

\textsuperscript{16} Health and Safety Executive, 2006  
\textsuperscript{17} Audit Commission, 2007; HSE, 2006  
\textsuperscript{18} Audit Commission, 2007; HSE, 2006  
\textsuperscript{19} Department of Health, 2005
adaptable in providing care for migrants, if they are prepared to meet the needs of the changing communities in the UK (O'Donnell, 2006).

To assess and manage the changing service needs of migrant communities it is important to have high quality intelligence about the health of the migrant communities’ resident in the UK (Blomstedt et al., 2006). As noted previously the literature provides information on the process of migration having a mental health impact on generic migrant communities but there is clearly a gap in identifying specific mental health needs of communities originating from the new accession countries which joined the EU in 2004. In rural Dorset there has been a steady increase in the number of National Insurance registrations from overseas from 620 in 2002/03 to 1,280 in 2005/06\(^{20}\), accession countries accounting for almost half of the new registrations (46%). With no available information on the health needs of the migrant communities originating from the accession countries, living or working Dorset, there is clearly a need to gain intelligence on these increasing communities and assess the local provision of services to meet these needs. With the literature suggesting a comprehensive link between migration and mental health need, the current Delivering Race Equality in Mental Health Care agenda\(^{21}\), and the gap in local intelligence, it is extremely timely that the mental health needs of the target communities are investigated and local service provision is assessed to ensure the NHS is meeting its statutory duty to provide effective and appropriate mental health care.

5.4 Recruitment of researchers

Recruitment was conducted through local newspaper articles, local radio interviews and through a range of contacts and networks known to the coordinator. The coordinator had originally hoped to recruit a team of six but this proved to be too high a goal for the area. Two BME researchers were recruited from the local community and were employed as Bank Workers for Rethink. Eight people had showed interest but the project was unable to use six of these as they lived out of the research area and it was felt that in order to create community engagement the researchers needed to be from the target area. A Community Development Worker (BME) from Dorset PCT was also recruited as the original funding application was in partnership with the PCT. The research team attended seven training events delivered by UCLAN in Exeter and London. Some of them undertook the University of Central Lancashire accredited Certificate in Community Research. The research team had the support of the research project steering group and Uclan Research Fellow.

5.5 Steering group

The steering group consisted of the Project co-ordinator and community researchers, a Community Development Worker from Dorset PCT who made up the project team, Rethink Services Manager, Locality Manager from Dorset PCT, Public Health Team Manager from Dorset PCT, South West Dorset Multicultural Network Co-ordinator, Head of Community Care Operations East Dorset Adult and Community Services, Dorset County Council, CSIP South West Race Equality Lead, and Uclan Project Support Worker. They were responsible for guiding the team through all parts of the project and especially ethics processes.

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\(^{20}\) Dorset County Council, 2006

\(^{21}\) Department of Health, 2005
5.6 Study design

The qualitative descriptive study design consisted of two components:

1) community focus groups, and

2) semi-structured interviews with local mental health service providers.

The focus group method has been chosen to explore the target communities’ views on mental health and the local service provision, allowing subjects to give much richer answers in discussions than might have been the case using quantitative methods\textsuperscript{22}. The focus group is appropriate for this study in order to gather a broad range of responses from the target communities (Green and Thorogood, 2004), using group dynamics to stimulate discussion (Bowling, 2002).

The semi structured interviews were chosen as this allows greater detail to be gathered on any of the points raised by the interview. It offered the participants the opportunity to give as much information as they wished during the interview and being qualitative allowed a much richer data to be collected.

1) Focus groups

Data was collected using a prepared focus topic guide (see appendix 7), which included key themes and associated prompts. The seven-grief model (Achotegui, 2002) has been used to develop the focus group topic guide.

Subjects were provided with an information sheet, (see appendix 4), that allowed them to indicate their understanding of the research and the procedures involved before the focus group discussions were initiated.

The information sheet would have been translated into all 8 languages - from Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia- by accredited and approved interpreters according to need. The only translated material needed was in Polish in the end. All other documentation for the focus groups would also have been translated if needed.

Subjects were asked to complete a ‘core questions’ sheet at the beginning of the focus group discussions, to gather individual socio-demographic data. These questions were prepared by Uclan and all participants in the CEP are required to complete this in order to generate a comparable data set across all studies.

Under the direction of the facilitator, the focus group topic guide formed the basis of the discussions. A verbal contract between the researchers and the focus group participants was established and verbally communicated to the focus group participants when initiating the discussions, this included:

a) Ensuring all subjects were aware of the limitations of confidentiality in a group setting

b) Respecting other people’s opinions and experiences throughout the discussions

c) Facilitator is to maintain the direction of questioning using the prepared script

\textsuperscript{22} Peninsular Research and Development Support Unit, 2007
d) Respecting a diversity of opinion between the group participants

e) Ensure participants understand that should they become emotionally distressed there is an opportunity to talk to researchers or a third party regarding any issues that may arise from the discussions (research team will have identified professionals in which to direct participants after focus groups have taken place).

Four focus groups, with approximately eight respondents in each group, were organised; one in north Dorset, one in west Dorset, and two in Weymouth and Portland (due to higher number of new registrations identified in the south of the county). Sample sizes were necessarily small due to the complexity of the data being collected (Bowling, 2002). It was anticipated that four focus groups consisting of approximately eight subjects would be a sufficient sample size to identify common stories, themes, issues, and topics emerging from the study subjects. However in order to gather data from as many of the A8 community members as possible, we were able to offer additional individual interviews for those who do not wish to take part in a group.

The researchers, using feedback from community networks, identified the most appropriate settings for the focus groups. These settings promoted confidentiality, but remained comfortable and accessible. All venues were risk assessed after being visited in advance to ensure they were; safe, an appropriate size, suitably furnished, had the right degree of privacy and confidentiality, appropriately insured, fire precautions and procedures were in place, staff would available to help in an emergency, and to identify any hazards or risks.

It was anticipated that each focus groups would last approximately one and a half hours.

The full team of four undertook the focus groups. The two community researchers led the focus group and the CDW and Project Co-ordinator recorded the data and took notes.

Data (tapes and notes) were transported by car from the focus group setting to the Weymouth and Portland Rethink office directly after the completion of the focus group. Data was securely stored in locked filing cabinets at the Rethink office. Only staff working on the project had access to these. Taped information was recorded onto paper and the tapes were stored in accordance with ethics procedures, once the report was accepted. Tapes were transcribed by identified staff who were thoroughly briefed on confidentiality needs of the project. In the end the majority of the transcribing was completed by the project team.

No personal identifiable information was used in the recording and reporting of data. Any information and data presented in the final report will not be able to be used to identify any persons involved in the project.

Participants were given the telephone number and email address of the Project Co-ordinator so that they may contact him to receive feedback and report copies.

2) Semi-structured interviews

Semi-structured interviews were held with team leaders from each of the six Community Mental Health Teams (CMHT’s) across north, south, and west Dorset. A
total of seven interviews took place, one in each team with the exception of Weymouth and Portland (south Dorset), where 2 interviews were delivered with two separate lead staff, this being due to the structure of the team. The interviews took place within each community mental health team setting.

Semi-structured interview questions formed the basis of discussion with the team leaders of the CMHT’s. A combination of open-ended and closed questions was used. A standardised tool was used (see appendix 6).

This particular method was chosen to allow more complex issues to be probed, with the ability to clarify answers, and the potential to obtain more in-depth as well as sensitive information from subjects by using a more relaxed research atmosphere (Bowling, 2002).

Contact was made by the Project co-ordinator with lead staff at the six CMHTs.

The Project Co-ordinator and another researcher travelled to each CMHT and conducted the interviews with the CMHT lead.

Confidentiality was stressed when setting up and conducting these interviews. No personal identifiable information was recorded about the respondents. All information given in interviews remained confidential within the research team and for use within the project report. It is worth noting that although we were not presenting the data from the interviews with CMHT staff in a way that explicitly links individual staff members or individual CMHTs to specific ideas or quotes, CMHT staff members were made aware that the number of interviews being held were small and it may well be possible for readers to make these links for themselves.

Participants were asked to sign a consent form prior to taking part in the interview.

Interview scripts, tapes and notes from the CMHT interviews were treated in the same manner as those from the focus groups. Participants were given the telephone number and email address of the Project Co-ordinator so that they may contact him to receive feedback and report copies.

Study subjects:

1) Focus groups

Respondents for the focus groups were recruited using the following Inclusion Criteria which was decided after advice from the Steering Group; to originate from Accession A8 countries; (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia, it was decided to omit Malta and Cyprus as they are outside of the Eastern European area and data showed there were negligible numbers of residents from these areas) all genders with ages from 18-65 years, living or working in north, south or west Dorset.

A purposive sampling method was adopted, in order to sample the target communities, originating from the accession countries, in the identified geographical areas of Dorset. Subjects were identified and approached through established community links.
2) Semi-structured interviews

The recruitment of the semi-structured interview participants was through the identification of lead members of staff from each of the six local Community Mental Health Teams in the target geographical area. A total of seven interviews took place, as described earlier.

A purposive sampling method was adopted for the semi-structured interviews as it was identified by the project that the Team Leaders would be in a position to answer all of the intended questions.

Data collection:

1) Focus groups

The Primary Variables (what will be measured) were mental health needs, including; impact of life changes; knowledge of mental health issues; awareness of local mental health services; access to mental health services (including barriers); gaps in service provision. The other relevant variables were; Socio-demographic information age; gender; ethnicity; citizenship.

2) Semi-structured interviews

The Primary variables were; the scope of mental health service provision, including; types of services; communication of services; access procedures/protocols; knowledge of access by target population; recording of ethnicity; specific service provision for target population. The other relevant variables were organisation characteristics (name and location of organisation) and respondent details (job title).

Data analysis:

1) Focus groups

The data analysis was mainly descriptive. Transcripts were developed using the tape recordings of the focus groups. Key themes and concepts were identified in the transcripts, which were categorised.

A frequency count of the number of issues and views expressed by type was undertaken and contextual illustrations of the conversations were made.

Content analysis and coding was the methods used to categorise the qualitative data collected in the focus groups.

There was a small number of quantitative data collected through the core data sheet that the focus group participants are asked to complete. Data was in put onto a Microsoft Excel document and used to record and report specific demographic data.

2) Semi-structured interviews

The same content analysis and coding methods was used in analysing the transcriptions of the taped interviews, using the coding method predominantly to analyse the closed question data.
5.7 Ethical considerations

The project gained ethics approval from the University of Central Lancashire, (see appendix 5), but also gained the ethical approval with Dorset County Council and the Dorset Research and Ethics Committee (NHS) and also gained Research and Development approval (NHS). The latter two of the four procedures were followed after advice from some members of the steering group as the project were to interview staff members of local NHS and Social Care and Health organisations.

The main ethical consideration of this research lies in the focus groups that were held with communities originating from the accession countries, taking place in a number of community settings. The essential component of conducting the focus groups required the focus group participants having complete trust in the confidentiality of data recorded during the focus groups and the reporting of such data in a way as to make identification of individual community members impossible. Trust in any translations made through interpreters was also a necessary consideration. It was proposed that the research report would provide general feedback to participants constructively reviewing the mental health needs of the target communities and the level of appropriate service provision and specific areas where action could be taken.

All data collected on tape was securely stored in locked filing cabinets at the Weymouth Rethink office, the tapes were transported straight from each focus group to the Rethink office and were stored in a locked filing cabinet. Only staff working on the project had access to these. Taped information was transcribed onto computerised files and the tapes would be stored as per ethics procedures. Identified staff that were thoroughly briefed on confidentiality needs of the project transcribed tapes along with members of the research team.

No personal identifiable information was recorded about the respondents. Any information and data presented in the final and draft reports will not be able to be used to identify any persons involved in the project.

Participants were given the telephone number and e-mail address of the co-ordinator so that they may have contacted him to receive feedback and report copies.

Tapes from all the community mental health team semi-structured interviews will be stored in secure archive facilities once the report has been accepted.

Preliminary discussions with community mental health team leaders showed that the respondents were happy to be transparent and did not require strict confidentiality and anonymity. However, should the pilot have uncovered more sensitive topics that may have required confidentiality, this would have been reviewed, and respondents would have been given the option of anonymity and confidentiality.

The ethical procedures for this project turned out to be very long and complex. The initial applications to UCLAN, (see appendix 3), and Dorset County Council were both prepared and approved successfully and quickly. However despite the project feeling that the services study was audit rather than research, the Dorset Research Ethics Committee (DREC) felt the project needed to have their approval granted as the study intended to interview PCT staff and that anyone in the general community
would be user of NHS services in the area. It was also necessary for the project to gain Research and Development approval (R&D). The ethics process was very complex and time consuming and resulted in various parts of the methodology having to be changed as well as a ten week delay in starting fieldwork as the project finally received approval at the end of the first week in December. R&D approval was applied for immediately and approval followed on the 31st December. This in total caused a two and a half month delay in proceeding with the fieldwork. Despite the frustration of the delays, the process was useful in the fact it really focused the methodology but it did require the rewriting of every information sheet (see appendix 4), consent form (see appendix 5), recruitment posters, research protocol, it required a supporting letter from CSIP as sponsors and a very in depth research approval form completed on-line with hard copies necessary as well. The coordinator and CDW from the project also had to attend an approval meeting in Poole which saw them facing a table of sixteen people, to answer questions on the project. One of the surprises from this process was the ethics committee suggesting focus groups to be held with single nationalities from the target population. They made the point that the mix of translators used in a mixed group would make it very difficult for the smooth running and effective data collection, however they did state that part of the reasoning was due to the possibility of the different nationalities not getting on and the possibilities of unease amongst them. The project decided to conduct one focus group with different nationalities as it was known the participants were all friends and all spoke English well enough for there not to be a need for translators. Despite this very rigorous process, the ethics committee missed one major point: that opposition from the local community could impinge on the safe delivery of the focus groups. This actually occurred and is covered in later in this report and is of concern that the ethics committee identified unrest between participants but never considered it from our own native population.

5.8 Limitations

The main limitation found by the project was the difficulty of access to the target population and also the recruitment of researchers. Without any community organisations to offer support to Eastern Europeans at this time, there was a huge difficulty in actually finding the people let alone offering them the opportunity to take part in the project. Despite the huge spread of publicity and the use of every network known to the team the resulting low number of 7 participants for the focus groups and one one-one interview was disappointing. The same is true for the recruitment of researchers.

Another possible limitation included the fact that most of the target population were thought to be working long and hard hours and that they would not feel like taking part in such a study after a day’s work. To that end the focus groups were held during the evenings.

In terms of the study design there were limitations that were worth noting to ensure they were taken into account whilst conducting the research and were acknowledged when analysing the data. Group dynamics may have limited the expression or elaboration of less acceptable opinions or the views of those seen to be lower in a status of hierarchy. Local cultural and political considerations may have also limited the range of views expressed in the focus group discussions (Green and Thorogood,
2004). The experience and skills of the researchers was important in reducing these limiting factors whilst collecting the data.

In terms of the in-depth interviews, the limitations that could have been presented are that interviews generally only provide access to what people say and not what they do (Green and Thorogood, 2004). The interviews were based on trust between the researcher and the subject, with the researcher re-enforcing confidentiality to promote the supply of honest accounts.
6. THE FINDINGS

This section introduces the findings from; the core questions, the focus groups and one to one interview and the CMHT semi structured interviews.

The project acknowledges that the small sample size may not be representative of the target community. During focus group data analysis, the team looked for trends of discussion that became apparent in all three settings which included the one-one interview and used these for basis of the relevant sections of the discussion and recommendations.

6.1 Core questions

The data in the following tables is made up of the core information requested by Uclan have only included the 7 focus group participants in this information. The one to one interview participant did not wish to complete the core questions.

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Table 6. Gender:

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<tr>
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Table 7. Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Number</th>
<th>Explanation of other</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>Estonian</td>
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<td></td>
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</tr>
<tr>
<td>Hungarian</td>
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</tr>
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<td>Latvian</td>
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<td></td>
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</tr>
<tr>
<td>Lithuanian</td>
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<td></td>
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<tr>
<td>Polish</td>
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<tr>
<td>Slovakian</td>
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<td></td>
<td>29</td>
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<tr>
<td>Slovenian</td>
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</tr>
<tr>
<td>Other</td>
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<tr>
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Table 8. Were you born in the UK:

<table>
<thead>
<tr>
<th>Born in the UK</th>
<th>Yes</th>
<th>No</th>
<th>Percentage</th>
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</thead>
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</tr>
<tr>
<td>Total</td>
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<td>7</td>
<td>100</td>
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</table>

Table 9. If no, how long have you lived here:

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Total</th>
<th>Percentage</th>
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</thead>
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<tr>
<td>Less than a year</td>
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<tr>
<td>1-5 years</td>
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<td>72</td>
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<tr>
<td>6-10</td>
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<td>28</td>
</tr>
<tr>
<td>11 years or more</td>
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</tr>
<tr>
<td>Total</td>
<td>7</td>
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Table 10. Are you a:

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Other explained</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>British Citizen</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Refugee</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Asylum Seeker</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
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<td>EU Citizen 3</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Resident 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Spouse 1</td>
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<td></td>
<td>Belarus 1</td>
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</tr>
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<td>Slovakian 1</td>
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</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 11. What is your first language?

<table>
<thead>
<tr>
<th>Language</th>
<th>Spoken</th>
<th>Percentage</th>
<th>Written</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hungarian</td>
<td>1</td>
<td>14</td>
<td>1</td>
<td>14</td>
</tr>
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<td>Polish</td>
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<td>Slovakian</td>
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<td>29</td>
<td>2</td>
<td>29</td>
</tr>
<tr>
<td>Other</td>
<td>1 Russian</td>
<td>14</td>
<td>1 Russian</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>100</td>
<td>7</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 12. Which languages fluent in?

<table>
<thead>
<tr>
<th>Language</th>
<th>Written</th>
<th>Spoken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Czech</td>
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<td>2</td>
</tr>
<tr>
<td>English</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>French</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hungarian</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Polish</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Slovakian</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Russian</td>
<td>1</td>
<td>1</td>
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</table>
Table 13. What is your religion:

<table>
<thead>
<tr>
<th>Religion</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>3</td>
<td>43</td>
</tr>
<tr>
<td>Christianity</td>
<td>4</td>
<td>57</td>
</tr>
<tr>
<td>Buddhism</td>
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<td>0</td>
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<tr>
<td>Hinduism</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Judaism</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Islam</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sikhism</td>
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<td>0</td>
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<tr>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 14. Sexuality:

<table>
<thead>
<tr>
<th>Sexuality</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesbian or gay woman</td>
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<td>0</td>
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<tr>
<td>Homosexual or gay man</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Heterosexual or straight</td>
<td>7</td>
<td>100</td>
</tr>
<tr>
<td>Bisexual</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Do not wish to answer</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other (please explain)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 15. Do you have a disability:

<table>
<thead>
<tr>
<th>Number</th>
<th>Yes (please explain)</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Percentage</td>
<td>0</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>
The only core data collected during the one-one interview states that the respondent is a Polish male and has lived in England for 3 ½ years. This was gathered during conversation and not from the data sheet completed by focus group participants as the participant refused to do this and also they refused to be audio recorded resulting in the researcher present at the interview taking notes. Core data was not collected from CMHT staff as it is acknowledged that the majority of the local workforce is of white British descent and the data was not thought to be entirely relevant compared to the focus group participants. In hindsight, considering the value of data on staff ethnicity to monitor if the staff group reflects the community ethnicity, this would have been useful.

6.2 Focus groups and one to one interview

The project acknowledges that due to the relatively small amount of data collected that this information may not be representative of the Eastern European living and working in Dorset. However it is felt that some of the evidence we shall illustrate is extremely valid and should be useful for services preparing for the target population accessing their services. At the point of realisation of low uptake for focus group participants the project took a decision to slightly widen the inclusion criteria to take account of a contact made by one of the researchers.

The data from the two focus groups has been analysed alongside the one to one interview that took place in Weymouth, because the same topic guide was used to conduct both the focus groups and one to one interview. The research team experienced difficulties with sound quality at the Bridport focus group but two of the team had taken notes during the group and these were referred to when conversation became inaudible during transcriptions. This was not an issue at the Weymouth focus group and the recordings were clear enough to have a full transcription made. The one to one interview was recorded in note form as the participant refused to be audio recorded.

The data was broke down into seven themes which will be covered individually in the following chapter.

Mental health indicators:

There appeared to be many indicators which could lead to mental illness which came out during the discussions. Some of these were echoed throughout the three sets of data and some were individual to members of one group or one to one interview.

The project has perceived that the time of arrival in this country and the time taken to settle and get used to the way things are done is probably the most stressful. It is at this point that services need to be most prepared as generally peoples language may poor and the understanding of systems and services will be fairly limited to nonexistent:

(on arrival in country) “I think I was really depressed; it was a very, very difficult time for me, really difficult, because this great big adventure I was hoping for was a complete fiasco, it was a complete fiasco, oh it was just terrible, such a hard time, it was the worst bit of my life so far, I’m really pleased it’s finished.”

“....and there was a time when actually I was on the phone to my mum crying because I failed myself, I have to come back after a few weeks, I went through all
this journey and all this hassle to come to England I was thinking to coming back but I knew deeply that I had to stay and prove myself and I had to stay for a bit longer and at least earn the money that I lost coming to England...."

".... I wanted to go back home...."

"....thinking of London, I think it was just such a miserable time, everything about it, work wise, as I said I was underpaid, everything was so expensive and no good friends around, even if they were, it was just too busy for me, it was just too much."

Part of this unease was perceived to be due to the loss of support of family and friends:

"....sometimes you just want someone to run to, like your mum and dad and you just to go and say hi mum, you know I’m not that brilliant, you know let’s just have a cup of tea, then you’re fine. You know sometimes it’s just that, then just dropping in."

"Well I was very young, I was only twenty so it did affect me. I was feeling a bit low, it was the first time I left home and I was a bit unsure and the first place was London from my cosy, lovely home, family around, I went to London with no family or faces, no friends, no-one."

Several of the participants found finding work to be difficult and in cases upsetting when unable to secure employment, especially when in their home country they have had held down responsible jobs. The project perceives that being a professional but being unable to gain employment in your field of expertise and loss of status must put pressure on you and have a negative effect on self esteem and confidence:

".....it was just, you know, having a professional qualification back home and then not recognised here, and I can’t get a job in what I am qualified in because I’ve got no experience, and I’ve got no experience because I can’t get a job, so it’s a bit of a vicious circle...."

"I feel sorry for myself and I don’t do anything to change my life and I can’t get a job as a psychologist because I haven’t got any experience in this country...."

(effect of loss of status) "....it was like I felt I was misunderstood sort of not appreciated.... I work in a nursing home as a care assistant and I’ve stuck there for three and a half years ....."

"A lot more status, then coming over here we start from scratch basically and I just feel, thought oh, you know, there was a little bit of frustration that I couldn’t get a job. Not really, because I lost the job I had in Slovakia but it was just because I couldn’t get a job over here.........I was sort of crying towards the 15th application, you know and I still didn’t get a job...."

"I mean for me I feel quite insecure and upset when I couldn’t get a job and I felt so dependent on my aunty, you know, I am an adult person and am completely dependent on somebody else....."

One participant found finding housing really difficult:
The participant noted that it was very difficult to get accommodation arranged when coming to England, taking 4-5 months to find a suitable house for him and his family.

The participant implied that when private land lords found out the participant was Polish there would be ‘nothing available’. As soon as the participant provided a reference from the agency he managed to arrange accommodation.

Another difficulty that came across during the research was of the feeling of alienation, of not belonging. This along with isolation could cause at the minimum apprehension and perhaps major stress which could lead to depression:

“But sometimes like you said people could treat me like oh it’s another person, another foreigner, in a stupid way, like I was stupid or something....”

“....but then being among English people being the only Polish person I felt alienation....”

“You sort of know that you don’t exist somehow.”

**Language barriers:**

Language barriers were apparent in all sets of data. The project feels this could have negative effect and make life really difficult if not impossible, particularly if a person was in need of help and needed to access services:

“I thought I could speak English I thought I had the basics cause I had in college and stuff, I was studying for a few years but coming to London it was just, the people were talking fast and slightly different form my teacher [laughs] so I was very low for a very short time I didn’t like this language [laughs]... I was really fed up because people couldn’t understand me because I was talking with an accent I couldn’t understand the accent so it was very, very frustrating for me, I think for a few months.”

“....and they come to ask for assistance at this shop and again I can’t help because I have language barrier.”

“....just because they didn’t understand that I am from foreign country, I just came to England, and it’s very difficult to adjust, my English is poor and they expected me to do everything that they did or they thought and if I couldn’t understand it’s like oh yeah you know, stupid ways....”

“But it was just, sometimes you couldn’t express what you wanted to say, because there was that little bit of English barrier and they probably did look for something better....”

“I had problems there, I couldn’t adjust myself because of language as well, I didn’t speak English really well....”

“....6 sessions with psychologist, that, ah, I didn’t like it because my English language wasn’t good enough, so I didn’t understand everything.”

“....I didn’t have a job because my language, I didn’t speak English....”
A participant said that there were too many forms to complete and when looking at the forms they don't understand them, they always have to ask a friend to help them complete any forms because of the language and noted how complicated they are.

The above all show how language difficulties can impact on life in a new country and on picking up on this the researchers moved the discussion towards what would be beneficial in terms of overcoming the language barrier:

“...you just know nothing, you can’t do the simple things, like bread, when you go to the supermarket and you don’t know where it is and you can’t ask anything, I think a telephone line in your own language.”

“Yes, a help line in your own language.”

“....you could just phone up, you know you can say I’m feeling this or this, but you could speak in your own language.”

“....yes, you need some information or where you can get help in your own language, you know if you, I don’t know, probably did have something where you, well if you don’t understand all this you can say look, thanks for your, you know you can phone this number and they will tell you, explain to you in your own language, you know....”

“We do quite often take the children to the GP surgery... and you see flyers about backache and whatever but you only see it in English not in any other language. It is not in any other language. If there was, you know if you would like more information in Russian or Hungarian or whatever.....”

The question was asked if you would feel more secure if you leaflets in your own language:

“Yes, it would be the highlight of your day as well. If you need it at that time you would know where to go to look for it or you could advise your friends about it.”

“....someone you could go to or phone and say you know, I have just arrived here and I have no idea how England works.”

All of the above quantify how people from Eastern Europe wish to receive information and help in their own language. The project perceives that it would be far easier to access help if you could understand the language by being able to speak or read in your own language.

Knowledge of services/how do you or would seek help?

The project began by asking where participants would go initially for help with health issues:

The interviewer asked the participant how soon they had registered with the GP when they arrived in England. The participant replied that they only registered when they needed to use the surgery. When they first came to England they didn’t know what to do, they had to ask friends. The interviewer asked them what they would have done if they hadn’t had their friends there to help and the participant responded by saying they would look for the first Polish person to ask.
“I would start off with my doctor [laughs], I think so, because if I find out there is something wrong I have to sort this out, I just couldn’t live like that....”

“Well I would probably do the same, like I would speak to my GP....”

“....yes and I would hope my doctor can help me.”

“....first time I would go to my doctor....”

“....if I was on my own I would definitely need a hand....”

“....but if I wasn’t coping at all I would go to my doctor.”

“I think we all end up going to the GP’s.”

All of the sets of data illustrated that the participants were aware of GP’s and that this would be their first port of call for help or advice. None of the participants spoke about accessing statutory mental health services. One participant had accessed psychology but this was in the private sector which was felt to be not in context with the study apart from the language difficulties discussed earlier. We then moved the discussion towards what would help in regards to accessing services:

The participant was asked if it would help having a leaflet in their own language:

“Yes, people would go but they can’t because of the language.”

Participants were asked where leaflets in their language should be available from:

“They should supply them (GP surgeries) with leaflets which would contain the.... the languages and addresses of support groups.”

“There could be flyers at schools and at libraries and GP offices.”

“I suppose it could be helpful because quite a lot of people send their children to school....”

“Citizens Advice Bureau, yeah.”

“....and I would research it on the internet as well.”

“....yeah the Internet, why am I feeling like this....”

Participants then went on to identify that a support worker would be very useful in terms of information and access to mental health services:

“....somebody who knows, I mean whatever problem you have, somebody to know what help is available so if you got problem with this you go there, if you got problem with something else, sort of who can give you sort of direction and I would say....another important thing for Polish people is having someone speak Polish on the other side of the phone because if you can’t speak English very well and if you pick up the phone....”

“....somewhere where you can either go or you can call and there would be somebody to sort of send you in the right direction, like if you feel depressed you can go there... if you think you have got problems with drinking you can do that....”
“I think it would be very good to have an Eastern European person in a small town like this which you could talk to because of the culture differences...yes someone who could translate between the two cultures really, I think a lot of people would avoid going on anti-depressants if there was trouble....”

“I think it would also be very good to have a support person available because it takes you years to work out certain things which are bothering you....”

“And if you could have a person to go to, you could have a good laugh, she could explain to you that is how it is and problem solved. I think it would be very important to have a person, a place that coaches. ”

All of the above show the relevance and importance of having a support person/agency available to help people find relevant accurate information and understand how to access the appropriate services to deal with any mental distress.

Experience of services/expectation of services

All of the data sets contained some discussion around experiences of using health services, although this was limited to contact with GP’s and the issues this brought up. The project perceives that the participants were far from happy with the service from GP’s:

The participant noted some consistent problems they have had with his GP surgery; there have been regular problems with registration – each time they go to the surgery they need to re-register because there is no information about them or their family on the system.

When the interviewer probed for more discussion around mental health the participant related to the issues regarding visiting the GP surgery again. They noted when going to the doctors with their children it is very stressful when the doctor does not know what is the matter with their children. The interviewer asked how this would be different in Poland and they responded that if the doctor didn't know what was the matter a referral would be made to a specialist.

“Yes, if you don’t trust someone you don’t go there do you.”

“Yes and before you can trust someone it can take many, many years on many, many levels.”

“I don’t believe in my Dr. I think it very strange all that happens when I go to my Dr he..... well I remember the Dr in my country.... here Dr’s when I have a problem, say don’t worry, take aspirin, all will be fine. [agreement and laughter]...don’t worry, take aspirin, all will be fine, what’s aspirin, it’s medicine. .....he says wait one second, he takes a book and finds something and says don’t worry, take aspirin.”[laughter]

The research team asked this:

“It sounds like you don’t trust your doctor?” and the reply was

“No I don’t trust the doctor, no.”
The participant reinforced the stresses with going to the doctors here in England and noted they wouldn’t always go because of the paracetamol issue. The participant informed the interviewer that they would go to the hospital just so they could see another doctor and get a better response than their own GP for any physical problems. The participant suggested that all Polish people in Weymouth have the same doctor, certainly their friends and family do. The participant noted that all their friends have had the same problem with the surgery as they had.

The issue about medication, paracetamol and aspirin in particular was raised in all data sets, as in the above two quotes:

The participant noted an example with a friend who was pregnant and was in labour but was delayed from hospital admission and told to keep taking paracetamol. The participant also noted that there are many times family and friends go to their GP and for any problems they get told to take paracetamol.

“When my Dr said to me, something like, you know, take these tablets, aspirin....”

The team were able to gain some insight into the culture of medication from Eastern Europe. The culture of the participants covered more fully in a later section of this report:

“Well I would probably do the same, like I would speak to my GP and would insist on some counselling if I knew it was really, really bad because I mean antidepressants is not going to take the problem away....it lifts your mood but the problem is still there, why are you not coping? Why is it happening? What is it? What is the cause of it?”

“I would want to talk about more before I take medication.”

“....experience of friends taking medication. Counselling wasn't possible for them on the NHS and they were put on anti depressants and they didn’t get any better.”

“If it comes to mental health, we would rather talk about stuff than just be prescribed a pill....I don't really want the pills I just want to talk about how I feel and just want to be understood [others agreeing] and from that will come the understanding of either just get on with it yourself but you need someone else to look from the outside.”

“....also in my country they would explain to you what they think, you know you would work with your Dr, you work together to find a solution but here they are very patronising and I find them patronising....”

“Yes or just listen because sometimes you just someone to listen they don’t actually need any medication you just need someone to listen and as you are talking it comes in your head, oh this is the solution this is how I need to, you know....”

The above quotes illustrate the experience of attending English GP’s is not in keeping with the participant’s wishes and can contribute to a feeling of misunderstanding and mistrust of services.
Stigma of mental health illness

As the research team felt there may be a stigma attached to mental illness in Eastern Europe they steered the discussion towards this and directly asked: is there stigma in your home countries:

“The people tend not to, I mean first of all going in to any sort of therapy is expensive and there is not many private places, if you happen to go to a public clinic, people are not very well trained because the majority of them have just finished five years of university and that’s basically it, they don’t do any... much more, or they do like a stint in a mental hospital and they don’t have their own therapy and stuff and they can be very judgemental so I don’t think it’s not a very good quality and I remember doing some work away training and worked in a psychiatric hospital and there was this psychologist and she was twenty eight something and there was this woman, one of her patients, and she was trying to commit suicide because she was pregnant but it wasn’t because you know to take her life it was to get rid of the baby but it didn’t work and she said to her you are emotionally immature and it was so unprofessional....”

“to say that in front of everybody, and I said, ‘oh my God’ and that would stop many people actually going to it...and God forbid if you go and stay in the psychiatric hospital....”

“....in Slovakia if you go to a psychologist, everyone considers you to be bonkers.”

“....a girl I used to go to school with, she had a nervous breakdown, she was in a psychiatric hospital and her family hadn’t visited her and she has been there for a year so it is really, really terrible....”

“So, I think everybody think if you say somebody is mentally ill they think they’re crazy.”

Theses quotes illustrate the respondents feel there is definitely a stigma attached to mental illness in Eastern Europe, that may come to this country with the people that migrate here. This may be one of the greatest challenges to be faced by services.

Culture

The data shows that the way language is used in Eastern Europe is much more literal than here:

“I would say that in Poland when you ask you someone you can be a bit more direct and you are not being seen as rude, whereas here it’s just like English people go round it....”

“....it's just the way this culture is, it's like people say how are you, they don't really care do they, whereas in Poland and you meet somebody and actually ask you, you know such a silly thing, how are you?, you actually expect people to go on about your troubles, whereas here, people don't....”

Talking and being listened to is very important as is being able to trust services:

“....just listen because sometimes you just someone to listen they don’t actually need any medication you just need someone to listen and as you are talking it comes in
your head, oh this is the solution this is how I need to, you know, and it doesn’t really need to be a psychologist because in Slovakia if you go to a psychologist, everyone considers you to be bonkers.”

“It’s just having someone that you can phone or go to, and he’s not going to let you down. Because if someone lets you down you don’t go and ask for help again. That’s how I would feel if had been somewhere and I was let down I wouldn’t go there for help again because I would know that probably next time, it’s probably in my nature, that next time I would be let down again.”

The data shows their attitude towards medication and looking after one’s own health:

“....in our family the last resort is to take tablets.”

“....we avoid medicine. .... honey and lemon and ....[several people agreeing].... using herbs, using diet. Very different from here.”

“....we were brought up to be responsible for own health. Prevention is very important. I saw the van which does the mammograms, and because in Hungary they are very happy to do anything like that. I walked up and said that I wanted to have a mammogram because I thought it would be the right thing. They nearly called the police on me they just didn’t know what I wanted, you know and because we are responsible about our health, we would probably turn up much earlier at the GP for advice and we don’t necessarily want to go on sick leave.... and don’t like pain killers and we end seeing people privately which we can’t really afford.”

“....and I didn’t want to be signed off and the Dr just couldn’t understand why I didn’t want to be signed off, why I wanted to carry on working until my maternity leave.... and I said well was there any permanent damage I could do and he said no. Just a couple more weeks of work is not going to do any damage.”

However in the case of mental health, the attitude is different to that of general health:

“....basically you have got this attitude about pull yourself up, get yourself together, where as sometimes this is just not possible and it doesn’t work like that if you are really in a sort of dark, difficult place because it makes it worse....”

“I think we have just to get on with things. If I was depressed I would still carry on.”

“I would refer back to my own culture but saying that, if I got really bad I would actually seek help. You know but if I knew that I had got to a point where I couldn’t carry on I would actually go. (go to GP).”

The discussion has already shown that there is a large stigma to mental illness it also shows that addictions are not looked at in the same way and that the focus group participants perceive that men use alcohol to dismiss health issues:
“...treatment alcohol addictions, any sort of addictions is acceptable because alcoholism is such a big problem in Poland, it’s acceptable to be an addict and drink and sort of like use physical violence but God forbid if you go and get some help and try to kick the habit it’s being seen as unmanly if you know what I mean, you know for a man not to drink, so people are actually ashamed to go and get help....”

“...they (men) would just try to dismiss it very quickly and they would get sloshed anytime anything goes wrong....”

The data also showed conflicting evidence between genders when asked what is a mental illness? The male that was interviewed replied:

The interviewer asked the participant what they knew about mental health. The participant recognised stress as relating to mental health.

Whereas one of the participants of the focus groups made up of entirely females gave this reply:

“So you know, if you say you are depressed or something, they don’t think it is mental health.”

**Racism**

This is an issue that became very close to the project after the issues raised that forced the cancellation of the North Dorset focus group.

The interviewer asked if the participant had had any experience of racist incidents. They noted they had not but some of their friends had experienced some nasty verbal from young people but they just ignore it. The participant mentioned another incident when they changed employment there was one person who was nasty to Polish people all the time but again the recipients ignored this.

“Oh yes, I had a small incident in Bridport one man said to me oh you in different country, I don’t have job because you’re taking my job....”

“....when a brawl broke out, I was followed out by 2 guys in a supermarket and they followed me out .... and they surrounded me and they told me that I stank, yeah stink. Yeah, so. I was feeling really hurt and I thought do I really smell? But the anger and the feeling of it , made me ask me ask my English friend and they said it’s not actually a about that I smell. I did find it a bit scary.”

“I was more and more withdrawing myself. I worked in a (inaudible) for those years and ah... ah... I was bullied at work, I didn’t know what bullying was because it won’t happen to me, so it took me about 2 years, to understand this is bullying and it has to be stopped....”

“When I came over here and I got married, the thing was the, I started to be a little bit paranoid towards the end, because you apply for a job and you apply for another one and you apply for another one and when you’ve applied for your twentieth and you still haven’t got a job you sort of start to feel like, oh do they have something against me because I’m from a different country.”
“I have a child and that child goes though the schooling system here, I have a 11 years old son, who started his schooling at county primary in Bridport and he was bullied through from first day onward to when I moved him to a different school. You need a lot of friends you would need, without having your family around.”

Along with the events that occurred to the project, these quotes show an aspect of the area we live. If we are to gain the full trust of the migrants in our county we need to stop this kind of racism occurring.

6.3 CMHT Semi Structured interviews

Background/overview

1. Can you explain the main responsibilities of your role and the organisation and team you work in?

The CMHT’s in the study cover the entire area of the research. Weymouth and Portland CMHT in the south of the county has two Team Leaders interviewed as the team is split into two, the DART and Recovery Team. Blandford CMHT is in the north of the county along with Shaftsbury and Sherborne. Dorchester and Bridport CMHT’s are in the west of the county.

All of the respondents were team leaders at CMHT’s but one is acting team Leader whilst the main Team Leader was seconded to a Locality Managers position at the time of the project. All have roles that include line management of staff and the general running of the mental health services. Three of the respondents were Approved Social Workers and their role also includes overseeing the other Social Workers, organising rotas and generally and making sure the Mental Health Act regulations are upheld. The other four respondents were Community Psychiatric Nurses. All of the teams are multi-disciplinary consisting of staff from Dorset PCT and Dorset County Council Social Care and Health.

2. Can you give an overview of the mental health services you provide?

All of the teams involved in the research, apart from the Weymouth and Portland DART team, mainly deal with secondary mental health service users that have a consultant and are registered on the Care Programme Approach system (SEPIA is replacing this). The DART team is different in the fact that they are an assessment team that does only very short term work with people but refers them on to the Recovery Team for longer term work and case management. All teams accept self referrals and the Blandford team will accept referrals from family, friends or anyone who knows a person as long as they have told the person that are going to refer them.

3. How does your service promote its mental health services?

Note: individual identifiable information has been replaced with a description in brackets for the remainder of the questions.

Currently one of the seven teams proactively promote outside of referral agencies such as GP’s: “Usually through the GP surgeries, the mental health forums, the Hub and so usually allied services would be the main focus for that, obviously the NHS
website for the Dorset area as well, would sign post people to us and also obviously word of mouth..."

The other six services do not currently promote their services outside of referral agencies such GP's.

One of the teams said in the past promotion was wide spread within the community but in recent times it is something that they have not got actively involved in: ‘We have done in the past, we have when I used to be the link person with GP surgeries we used to give leaflets....” “Less so now and I would say more so because of the development of primary care services which are accessing more people who aren’t already in the service...”

Other answers included one who felt there was no need. “I think probably this is the consequence of a small area, people know where you are, where probably in a town they don’t, you’d have to search it out, people don’t have to search it out, they just know (laughs), where the (CMHT) is.”

One noteworthy answer was ‘When I took up the post (time ago) my predecessor told me he used to go to the Council meetings just to try and promote mental health and he was told by one of the Council workers there that there isn’t such thing as mental health problems in Sherborne.”

4. What are the referral pathways and procedures to your service?

Four of the services report that referrals come through GP’s and self referral.

Two operate an open door policy, one of which is more open than the other: “so that anyone can refer themselves, and they can be referred by anybody as long as the person that is being referred knows about it. So your friend, your neighbour, your mother or father can come and refer you as long as they have told you are being referred.”

The final service takes referrals from secondary mental health providers “DART, medics, inpatient units and psychologists.”

Delivering Race Equality and local service provision

5. How much knowledge of the Delivering Race Equality in Mental Health Care agenda do you have?

Responses varied, one had some knowledge of key the issues of DRE: “....I don’t know much about the reports. We certainly as a team know the issues of the care in um... and know what problems it causes on misdiagnosis and general emphasis, like black people tend to be sectioned more. It is not an issue round here, we do have people from a wide variety of ethnic backgrounds and were just trying to count them before we came to this. From a team point of view we have people who have worked in London, have worked in inner cities, lived in inner cities, so they are carrying their knowledge through to us....”
One felt that it isn’t a priority as BME people are not in high enough numbers: “....I haven’t really put a high priority on it.” “I suppose it’s one of those hidden really, if it’s not in your face and you don’t see different races walking down the street or coming in through the door then it doesn’t become high on the agenda ....”

One respondent did not show any examples but had awareness of the agenda: “I know of the agenda, I know what the emphasis is, to promote um, the equality, an equality service for people from East European countries because of the growing populous that we are getting, so I am aware of that bit....”

Another said: “....no knowledge but would look on Trust website and intranet.” “....would be able to access intranet and look up any policies on race equality.” They had also been on training days on race equality.

One had found information due to a referral: “Very little. It’s what I’ve read on the national website for myself simply because I received someone who was from Afghanistan originally. Um.... about 18 months ago and I was searching that information out for myself. I also looked for training for myself and have been unable to access any. I heard there was a course but I didn’t know anything about it until someone had come back....”

6. How much knowledge do you have about the demographics of the local BME communities in this area?

One had statistics from a three year old demographic study carried out as part of the process for Practice Development Units and knowledge of the local town: “We have got a few other people of different ethnic minorities that are well integrated in to the community. There is a Thai community, bits of Thai community, lots of Irish staff (laughs) I’m aware of a Turkish place in town and also from Afghanistan....” “Indian population, mostly restaurants and things. So it is really what we have picked up on from here so rather than demographics....” “...but having said that a couple of years ago, 2 staff from here, 3 years ago as part of the PDU project that we we’re doing, that’s Practice Development Unit, they have done a demographic study of this area so that information whilst in not being in my head could be available and I know exactly where to get it.”

One respondent gave this reply: “Yeah, you have got a core, it’s a very stable society around here it’s a rural area here don’t forget, but it does have an influx because there is quite a lot of mobility isn’t there really, mobility seems to be round here more of a white flight isn’t from London and Birmingham, coming down here, with the odd individual that comes down here from another background, quite a number of people have married people from overseas and they have returned back to Dorset and have issues with Thai girls marrying local farmers and things like that. That can be a problem because there is a cultural thing there isn’t there....”
One initially said: “I have no idea, I don’t live in the area.” But then added: “In summer we get quite a catchment of different kids, so we might get Italians, German, different nationalities in the town and they are coming to learn English....”

One respondent had no knowledge of the local demographics other than through monitoring ethnicity of service referrals.

Another respondent had some awareness and recognised the need for the knowledge: “Not an in-depth awareness. I mean that’s something that’s been highlighted as a need of something we need to do as part of the locality, identify what the needs are and establish exactly what the baseline is.” “I am aware there has been an influx of Eastern European community here...” They began to question why no referrals for this community had been received: “....so they are either very healthy in terms of their mental health or it’s been managed in some way.”

7. Are you aware of any specific mental health needs of the local Eastern European community?

Three of the seven respondents felt there were specific mental health needs for the target population. One stated two diagnosis’s two identified language difficulties as being perceived issues relating to mental health needs: “....would imagine that post traumatic stress disorders from certain countries would be quite high, um, I would imagine that depression because of the change of circumstances....”

Two felt language barriers. One of these replied: “Maybe it’s more of a class thing or education thing with the Eastern Europeans ....” they added “The illness may present itself in a different way but that may because of the way the language is used.... It may be very difficult on a first assessment to establish whether they have a mental health problem or whether this is just a cultural interpretation underneath the core of the things.”

The other felt isolation as well as language barriers are associated to mental health needs.

8. Does your service record the ethnicity of people using your service?

---

Yes
No
Don’t know

All of the respondents reported ethnicity is recorded for people using the services. One respondent gave this reply: “....we tend to feel it is a tick box exercise. We can see the reasons for doing it but we are not quite sure how much value comes out of it when it comes down to individual working and individual practice ‘cause that’s what it is about isn’t it, this interview, how we do it here, so we will tick the boxes but it doesn’t reflect, it doesn’t give us any kind of feedback....” They went on to add “My cultural needs are probably a lot different than a guy brought up in Dagenham. I am a west country boy you see, so you know if you can make that differentiation...”
between like I said class, education and the rest, then that would be a more true reflection, you know it has to be done um..it’s fairly crude but we do it.”

Other respondents gave these replies: “Yes – ICPA (Integrated Care Program Approach)”

“Yes we do. Well Sepia insists that you do” (replacement for ICPA which records Care Plan information)

9. Can you use this information to identify individual ethnic groups such as Polish, Romanian etc.

   Yes
   No
   Don’t know

Six of the seven respondents stated that you could not identify individual ethnic groups from this data. One was unsure. However one respondent felt this data was unimportant compared to other indicators. Another respondent described the changes to the Approved Social Worker Mental health Act recording which now breaks down ethnicity into individual origins after this project raised awareness of the ethnic coding not being accurate enough to identify ethnicity such as Polish.

10a. How useful is this data to your team and to you as an individual?
   Prompt: where does it go, is it analysed etc

Six of the seven respondents felt this information to be useful with reasons being: useful for service planning, for business planning, to benchmark the community, to identify population. The other respondent felt the information was not useful for the team but was for the organisation (Dorset PCT). One of the respondents also felt this information could be better.

“I would like this data to be more useful in that we could draw more specific information off it, I think the data as it stands at the moment doesn’t allow us to type in religion, specific religion, or specific ethnicity....” “...would like to see more breakdown, even so far as GP’s, what are their referral rates and things like that....”

10b. How important do you think this data is?
   Prompt: the value the interviewee places on collecting such data.

Four respondents felt the information is important: “....extremely, you know, looking at skills mixes and things like that, you know, if they had more information about where we need to be putting our skills then that would make life a lot easier for me.”

“Well it should inform us…[long pause]… yeah it should inform us… what that translates to in practical means is access to interpreters or someone within that community who can help us.”

“Not directly no but I think it’s a statistic. It doesn’t actually tell you who’s walking in through the door, it might tell you, you know that that person is of this ethnicity, what
it doesn’t tell you specifically is what that persons problems are and how you as a service are delivering the care to help them.” “....well if I want more resources they’ll say your population in this catchment is and say my business plan would be saying well this is the resource I need because....”

“....important for identifying translation needs.”

One respondent felt it would not make any difference to service delivery: “That would be quite useful, that kind of (information), what is actually the diversity within West Dorset, we don’t get that information, we just get the sprinklings of people who know, that would be quite useful information. How it would cover our practice, I don’t think it would make any difference, because we’re going back to the fact that there aren’t a great number of people, usually a one-off referrals, we can individualise the service very quickly and respond to it well.”

The answers for the other two were unclear as they did not mention importance of data.

11. Within the last six months, approx how many Eastern Europeans have used your service?

12. What percentage of your overall client group does this signify?

Question 11 and 12 are grouped together and presented in table 16 below.

Table 16. How many Eastern Europeans have used the service in the last six months and what percentage of overall client group does this signify.

<table>
<thead>
<tr>
<th>CMHT</th>
<th>Amount of Eastern European people seen by service in last six months.</th>
<th>Percentage of overall client group. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blandford</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bridport</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dorchester</td>
<td>0</td>
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</tr>
<tr>
<td>Shaftsbury</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sherborne</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Weymouth DART</td>
<td>2-3</td>
<td>1</td>
</tr>
<tr>
<td>Weymouth Recovery Team</td>
<td>2</td>
<td>0.5</td>
</tr>
</tbody>
</table>
13. What services and resources do you currently have available for the Eastern European community? Prompt: i.e. translated materials

Three respondents replied that translation was their only resource. One replied that other people in the team are the only resource. Another replied that they have LIPS, an assessment tool to identify translation requirements. The other two respondents reported that they have no resources available for the target community.

14. What additional resources do you feel would benefit the Eastern European community?

Three respondents felt there is nothing that would help. One of these felt that the numbers are too low,

“Well, we’ve talked about that but there isn’t enough numbers, if you go and set up a centre you would be there on your own [laughs]..sitting for days on end waiting for your first customer....”

The other answers were: translators, leaflets in a variety of languages, one suggested Community Development Workers and one felt that they could offer a health check,

“...just say you know come and have an MOT... and if they didn’t know it was there a part of that MOT could be a mini mental health assessment just saying how are you, how are you settling....”

15. Do you have any tools in place to assess the mental health needs of the Eastern European community?

Yes
No
Don’t know

All seven respondents said they had no specific tool in place for needs assessment. Six of the seven felt that the standard tool used by the service would suffice: “....no different from what we would use to assess anybody else because I mean at the end of the day, apart from the language and the cultural differences....”

“The tools that we would use would be the ones used as standard anyway, I am not aware if there is anything different internationally to apply to different populations.”

One felt the standard tool would suffice, the skill would be in the way it is used: “Well, the specific tool would be the interpreter.” “I think the assessment would be different because there would be you know that kind of awareness of language difficulties and interpretation difficulties, so even if somebody spoke sort of English, still the way they would articulate their symptoms would cause you to pay a little bit more attention to say well is this because they are Poles or this because they are mentally ill....”
One respondent, after replying that they do not have a specific tool, questioned whether this is the case: “No. Like I said I haven’t got anything in any other language other than in English so the only, I mean the assessment tools, are in English....”

16. How effective and inclusive do you believe your referral pathways to be for the Eastern European community?

Three respondents felt this could only be achieved through GP response to seeing individuals from the target community: “I mean as I said it puzzles me that we haven’t had more and like I said GP’s normally respond at a drop of a hat to any distress......”

Three respondents felt that their services are not effective and inclusive for the target community: “I don’t think they are. I think that the fact that I haven’t been able to tell you what the population is in the area and that fact that we never see anybody you could actually argue that it isn’t effective because we’re not getting them in the door.”

The final respondent showed no evidence of inclusiveness but showed intent to be so: “I think that sort of what we offer would be no different in respect of anybody else, it would be equal to that except that we would have to tailor it to suit the cultural and language needs, you know obviously cultures have different thinking processes about, let alone other religions and things like, as long as you incorporate that and were mindful of that, which I believe my staff would be.”

17. How does your service promote its Mental Health services to the Eastern European community?

All seven respondents replied that they did not specifically promote their service to the Eastern European community and one felt that this should be in the role of Community Development Workers.

18. Are there any barriers to overcome that could help you improve on this promotion?
   Prompt: knowledge, tools/methods, budgets/resources

Three respondents skipped this question as they do not promote to the target community. The other four gave these answers:

“No barriers....”

This should be the PCT responsibility: “...... so I think the obstacle is, dare I say it the Trust needing to invest in people to do the job.”

The team understanding cultural issues: “Well I mean it comes down to a greater understanding from ourselves. I think we need to do some training and some understanding and some cultural awareness really.”

The final comment suggesting only the barriers that service users put up themselves due to lack of knowledge of services: “....so I’m not aware of a barrier because as far as I’m aware, I would help anybody but do they see that, now that may be a barrier from that side, I don’t know but I am not aware of a barrier....”
19. Do you have any means of identifying gaps in your current service provision?

If yes, how have you identified these gaps? Go to question 20.

If no, is there any reason for this? Go to question 21.

Five respondents reported that they had no formal means of identifying gaps, although one said through caseload knowledge and another through team meetings and liaison with other teams. The two others quoted through SEPIA (replacement for CPA) and raw data but did not specify from where.

20. What are the gaps you have identified in your current service provision and what effect do these have on people from the Eastern European community?

One respondent replied that lack of service users from the target community was a gap. One reported that: “....from our conversation this morning its coming to light to me that we not working in an inclusive way.” This is a very significant comment as the respondent gained awareness of the issues during the interview.

The other five have not identified gaps in their service.

21. In your opinion, do you believe there are any [other] gaps in your service provision and if so, what are they?

Only two respondents identified gaps which are adolescents and CBT delivery, “I think this Trust needs to get back to basics and actually invest in training people so we can deliver everybody a decent service.” and clinical diagnosis such as for dual diagnosis and personality disorder.

Delivering Race Equality Support Structures

22. Have you a person that is responsible for Equality and Diversity in your team?

   Yes
   No
   Don’t know

If no, go to question 23, if yes, go to question 24.

Only two respondents reported that their teams have a person in this role and one of these has two people sharing the role.

23. If not, is there someone responsible for this in your organisation?

   Yes
   No
   Don’t know
Four respondents reported that there was no one in the organisation in this role and one reported that yes there was but they had left and no one had told who had replaced them.

24. Have you/your team received any race equality training?

   Yes  
   No  
   Don’t know

Five respondents reported that one or some of the team have attended the training.

Two report that no one in the team has attended and one of these said that the training has been offered but does not identify the need.

25. How important is this training to you?

Six of the seven respondents felt the training was important, one saying “vital”. One of these did question the effectiveness of it though: “I'll have to wait and see [laughs]....” “I don’t know what the content is, but I think all information and knowledge is useful anyway....”

The seventh respondent felt the training was not important as they could rely on a team member’s knowledge to get them through. “Just talk about (name) for instance he spent many years in (an inner city) and so if he is not aware then nobody is quite honestly. So you could use him as a resource, he is our resource really.”

26. Have you any plans for personal development in the area of Equality and Diversity?

Two respondents have identified development through their Job Development Review and one of these wants to raise the profile of race equality.

One respondent reported that they will be attending Race Equality training but that was the extent of their development.

The other four respondents have no intention to develop in this area, one of them replied: “I have personally worked in a Third World country, so from my point of view I have done that and that carriers me through anyway.”

Delivering Race Equality future plans.

27. Have you any future development plans that will ensure a responsive and appropriate service for people from ethnic minority communities such as Eastern Europeans etc.?

   If yes go to question 28. If no go to question 29.

Three respondents replied that the teams had future plans. One of these was all of the team attending Race Equality training. One felt that they could bring it in to their business plan and another that they need to identify and action plan and lead for it.
The other four respondents said their teams had no plans for future development. One is waiting for someone to identify the need for them and one sees Diversity linked to class, education and status: “I’ve had an admiral and I’ve had the son of one of the most famous actors the world has ever seen, you know as oppose to I’ve had other lads who have spent their life in Bridport. So I can honestly say we do get that diversity in West Dorset…”

28. What are your future development plans to ensure a responsive and appropriate service; will they address any gaps that you have identified?

Only one respondent answered this question and reported that they are considering from the interview, of promoting in primary care: “....looking at development of primary care and perhaps the resources within that, from our conversations that we’re having you know it’s something that you could, I could promote in primary care”

29. What support and resources do you need to address for future development of your services to ensure they are responsive and appropriate?

The respondents gave the following answers:

A Trust centred equality and Diversity team to share resources etc.

One gave an answer that was not clear. For the purposes of clarification, the interviewer asked “The resources are probably there then?” The respondent replied “absolutely”. They felt they had all the resources they need.

One respondent identified translated leaflets would help address the need of the target population.

Another identified no resources and quoted added: “If I was living in the city, I guess I would have a much clearer idea but because it’s so rural here, its predominant ethnicity is white British, elderly....”

One did not identify any resource but was able to show how they would request any resources through their business plan.

One identified translated information on the PCT website.

The final respondent identified training.

30. If you had a wish list what 3 things would you like to change about the way your organisation delivers mental health services to BME individuals?

Two of the respondents had no wish list. The other five and gave the following answers:

Quality research on the target population and for specialist translation checking services.

Did not have a wish list and they surprised the interviewer by not knowing what the initials BME stand for.
Specific identified worker to access workers and feedback to the service, leaflets (translated) and training.

A service to address language barriers, better partnership working and for finance to address the resources identified by needs.

More appropriate leaflets and written material, in different languages. Ensuring staff are properly trained in race equality and written into organisation structure with regular updates and to raise the profile of race equality.

31. Is there anything you would like to add to the discussion?

Four respondents had nothing to add to the discussion. The other three gave the following replies:

“...it would be really great if this Trust could take, be um.... seriously invest in it get up to speed with it and not bury their head in the sand because we don’t have a big, they don’t see it as having a big ethnic, you know sort of culture around, so therefore maybe being able to ignore it, you know more than maybe other places might, might do.”

“...and I suppose you could say that probably Rethink, are not really geared for this area, they are geared to, they would perceive it to be where it’s at, it’s at here at a different level, they are obviously geared to a central government response, an inner city response, large metropolitan areas, and hence why we are doing it....” It was felt that there was a lack of understanding of the research and of the DRE agenda as a whole.

Reported that they have plans to network with international workers and this is seen to contribute to the understanding of needs.
7. DISCUSSIONS

The section will discuss the findings from the previous section.

7.1 The barriers

7.1.2 Research focus

The project group at first struggled to focus on a research area due to the demographics showing a BME population of 3.3-3.4%, (see appendix 1). The bid was originally for general pathways to care for the BME communities. This proved to be too broad, but the project was able to gain this focus after a member of the steering group reported that they had heard anecdotal evidence that the number of Mental Health Act assessments on Eastern European men, particularly Polish had risen dramatically in area. Attempts to verify this information proved to be impossible due to the Department of Health ethnicity recording data requirements not being able to capture ethnicity other than white European, which covers many nationalities and cultures.

7.1.3 Access to participants

This project has faced many challenges and obstacles in completing this research study. The target area has a diverse and dispersed BME community which has made access to the community very difficult. Apart from the South West Dorset Multicultural Network and the Dorset Race Equality Council which was undergoing a major restructuring at the time of the project, researchers were unable to find any types of community BME groups/services to help identify both researchers. Despite wide promotion of the project, including newspaper reports, radio interviews, a wide and varied network of local agencies and contacts, the coordinator was only able to recruit two researchers from the BME community. Eight people applied but six of these lived outside of the target area and it was felt that in order to create community engagement that the researchers needed to be living in the target area. A Community Development Worker (BME) from Dorset PCT also joined the research team.

One of the greatest difficulties was in recruiting participants for the focus groups. Again a very wide promotion of these focus groups was undertaken again using the press, radio, numerous emails and phone calls, posters being distributed all over the area, including every library. The research team perceived that the lack of community groups for the target population and other BME groups in our area made this task difficult. This was enforced when the pilot was carried out in Yeovil. Through the local CDW, a community group was contacted and it was arranged for the pilot to be fully attended at short notice. This illustrated the effectiveness of a support service in Somerset, an area similar to the one in which the research took place. Eventually the project was only able to capture data from seven participants in focus groups and one during one-one interview.

7.1.4 Opposition

The opposition reflecting a minority of local attitudes actually resulted in a focus group being cancelled (see below). If this attitude is picked up on by the target community, it is very obvious why they are not willing to identify themselves for
research such as this. This was not only visible for the cancelled focus group but also in some of the comments posted in reply to an article promoting the project in a local daily newspaper (see appendix 11 for web link to article).

The issue which most impacted on the project occurred in North Dorset relating to an arranged focus group in Sturminster Newton. The research team, in particular the coordinator received two racially motivated emails, one of these from a local Residents Association with links to the local borough council (see appendix 9). The other email (see appendix 10), was sent by an owner of a sports club in the area. These were both unsettling on their own but just days before the proposed North Dorset focus group a threatening telephone message was received by one of the team. A decision was taken to cancel the focus group for the safety of participants and the team. The coordinator and another researcher attended the venue to ensure that none of the participants were left waiting and at the potential of harm from opposition to the project. The local police sent two officers to wait with the researchers. There is a percentage of the general community in our area of Dorset that are unhappy with migrant workers being employed here and an article published by a local evening newspaper that was aimed at recruiting focus group participants drew some comments on its website (see appendix 11), that show this feeling. It was heartening to also see several comments supporting and defending the migrant workers. On the whole the general community showed little opposition and many were able to offer assistance the project.

7.2 Outcomes already achieved by project

Due to discussion with Dorset County Council staff and the project coordinator on ethnic coding and the wide bandings used for ethnic monitoring not being able to distinguish between different and specific cultures ie. White European rather than Polish, Slovakian; a decision was taken at the County Approved Social Worker Meeting that they would from that point identify the exact ethnicity of anyone being assessed under the Mental Health Act. The collected data from this improved recording would be able to identify any trends of ethnicity and should allow services to prepare when this occurs.

The two BME researchers are actively seeking employment in the mental health field.

7.3 Focus group data

7.3.1 Arrival in this country

On arrival in this country immigrants can find stress levels fairly high. Being able to understand the language can be very difficult as they can find local dialects and accents completely impossible to understand. Finding accommodation can be hard and finding employment can be difficult as well. As we all know it is important to have frequent contact with family and friends and loss of this is something that immigrants have to adjust to quickly. Loss of status can be difficult to cope with at the best of times and this must have a negative effect on people who left a country as a professional worker and arrive somewhere new to have the choice of unskilled work and very little else. Finally, to feel alienated by the population of a country you are living in cannot be easy, we all need to feel that we fit in somewhere in the scheme of life. All of the above reasons can lead to suffering mental illness which could lead
to needing treatment from the mental health services. This is probably the time when people need support but if they cannot speak or read the language and do not know anyone, how are they to go about this?

7.3.2 Language Barriers

Language barriers came up many times through the data collected and the project are fully aware from this at just how difficult this can make life for people in a new country. It can make even the essential things such as buying bread extremely difficult. All of the participants have been able to learn and use our language well but this wasn’t always the case. Some found it very difficult at first finding that the lessons taken in their own country are not enough to get by when faced with regional accents and dialects. It may be possible that others that have come to this country and have not been able to gain such a good understanding and use of English, which is essential to find out where services are and what they do.

7.3.3 Accessing health services

It appeared that all of the participants would use GP’s if they felt they needed to. Unfortunately the experiences of the study group were not always satisfactory, this is covered more in the next chapter. There was very little discussion around the mental health services. This could have been because only one of the group had accessed any mental health treatment and this had been in the private sector and because others did not wish to talk about. Hints of this are discussed in the later chapter on culture. In the regards to what would help to access services, translated leaflets/information was mentioned many times. Another idea that was mentioned throughout was that of a support worker who would understand the cultural differences and be able to signpost people to relevant services. It was mostly thought that someone form eastern European descent would be best for this role.

The discussions held about the experience of accessing health services were restricted to GP’s by the participants and one spoke about a private psychologist they had seen. The two focus groups and the one to one interview all had issues with GP’s prescribing medication, mainly paracetamol, when the majority of the time all they wanted to do was talk about their problems. This appears to be more like the treatment they would receive at home, although this was not specifically asked. The majority felt they needed time to discuss issues and not just be prescribed medication. This appears to be causing mistrust within the target community and appears to be part of the culture of Eastern Europe as the majority of participants spoke of talking and working with their doctors rather than taking medication. Registration at GP surgeries had proved to be fairly stressful for one individual, although no others had this same experience in the study but as stated we are talking about a small sample. It was also discussed by one person that the forms needed to be filled out at GP’s etc were too complicated to understand, particularly when the capacity to understand English language is in question. The person who spoke about going to a psychologist said that often the treatment was ineffective as she could not understand the language. GP’s are absolutely crucial as they are the main referrers for the secondary mental health services and if they do not get it right people may be left suffering. Another negative impact of this is word of mouth, information that would spread among communities from other countries and could lead to people not going to the GP until it is too late and problems can only be dealt
with by medication. The researchers perceive that this situation may be due to GP’s not understanding the cultural differences of the target population. It is positive that none of the participants mentioned any fear of services.

### 7.3.4 Stigma

The Eastern Europeans that took part in this study implied that there is a stigma attached to mental illness in their own countries. This stigma will travel with them to other countries that they settle in and may make them avoid mental health services at a time when the services may be able to help them much more effectively and possibly without medication. Once mental illness has a firm grip on someone it is far more difficult to treat, this can be made much more difficult if the person cannot speak the language well and mistrusts the service. From the discussions it appears mental health treatment is mainly having to be paid for and does not reach the standards of our country in the participants own countries. There is a lot of work to be done if we are to convince these people that it is part of life for some to suffer mental illness and that we have in this country, a free and effective pathway for treatment of it. Of course we need to ensure that this is the case for anyone of any particular origin.

### 7.3.5 Culture

The participants gave some very useful information about their culture. Their use of language is very to the point, they say what they mean and mean what they say, and this can be mistaken for rudeness. For an effective relationship services must be aware that time is essential in allowing people to say what they need to. This in turn will help build trust and create the opportunity for effective care pathways. It is essential to understand that the culture is one of using natural remedies for the minor ailments such as colds instead of the traditional use of medication, like Paracetamol. Wide prescription of medication without time for ample discussion and explanation could lead to mistrust of services. Despite the inclination to be forward thinking for general health issues, the evidence we have collected points to the fact that this is different with mental illness, depression at least. As a culture they are more likely to try and carry on with the effects of mental illness far longer and as a result go for help when in crisis. The focus group responses show that men may well turn to alcohol rather than seek help for a problem but the evidence from the one to one male interview showed that he saw stress as a mental illness but avoided any other issues around the question. However the focus groups made up entirely of females do not relate to depression as a mental illness.

### 7.3.6 Opposition from the local community

One of the most difficult challenges is that of the racism that exists in our area. Of course not all of our residents are racist, but those that are can make life difficult for migrant workers and immigrants. Fortunately the participants from this study group had all been able to deal with this issue well and have not been too upset by it, mostly they just ignore it. Never the less it is something that will have to dealt with and quickly, particularly if it involves children. It was very reassuring that all of the authorities contacted after the awful events experienced by the project team, reacted in a positive way particularly the local police force.
7.4 CMHT data.

7.4.1 Knowledge of DRE

It was identified that all of the respondents had a very limited knowledge of the Delivering Race Equality programme. Some of the answers stated that it is not seen as a priority and some inferred that a lack of a visible BME population in Dorset means there is no need to be aware of such issues because they are not visible ie similar to the indigenous population in appearance and “...not in your face....”.

The fact that the services are unaware of the ethnicity breakdown of the local community means they possibly could miss the need for a good knowledge of the programme and its aims and objectives that would help achieve a service appropriate to the needs of its own local community.

7.4.2 Knowledge of local demographics

It was identified that none of the services in the study have any useful knowledge of local demographics of BME communities apart from one service which has a three year old demographic study of the area. It is necessary to have the most recent population figures to be able to design services that meet the need of the entire local community particularly if it is found there is a measurable increase in any ethnic community.

7.4.3 Recording of ethnicity

It was found that all services are recording ethnicity but identified that none of them are using a system that can record individual ethnic groups, such as the target communities. However, as a direct result of this project the Approved Social Workers have amended their ethnic coding to show the exact ethnicity of any person that is assessed for the Mental Health Act. It is necessary to have accurate monitoring of ethnicity in order to be able to develop services that would be accessible and effective to any particular BME community if the figures show need. All of the respondents felt that this information was useful and important. One said it could be better if they were able to draw further specific information from it, such as specific religion and ethnicity.

7.4.4 Resources

Four of the respondents were able to identify resources for the target community. Three were translation resources. One respondent felt that team members were the resource. It was found that four of the respondents could identify additional resources to benefit the eastern European community, but one felt the numbers of the target community did not warrant this. The other answers felt translation and translated leaflets were needed, one felt that a Community Development Worker to liaise with the community and one felt a drop in health check. The project feels that there are a number of resources needed if the figures continue show a rise in the number of eastern Europeans in the area or any other ethnic groups. A person able to create links in the community would be in useful position to able to promote services and with the support of the appropriate services be able give information and signpost to the relevant service. They would also be able to gain feedback from individuals to help with service development.
7.4.5 Assessment tools

All of the services use a standard assessment tool for everybody regardless of their ethnicity. Six of these felt the standard tool was suitable as it was but one, as their awareness of the target population grew during the interview, questioned this pointing out that, how can a tool be effective if the person it is being used on does not understand the language it is written in. Initial assessment for mental health illness in secondary services can be a pivotal point in someone’s illness. If issues are not identified or if cultural beliefs are challenged, the effectiveness of access cannot be guaranteed and people can left in the hands of primary care when they need the treatment from secondary services or even worse detained (sectioned) because of behaviour due to unrecognised cultural belief.

7.4.6 Effectiveness/inclusiveness of care pathway

Due to the majority of the services relying upon GP’s referring people to them, there is no information/data to look how effective or inclusive this pathway is. All showed intent to this by stating at some point in the interview that they treat everybody individually at their services.

7.4.7 Promotion of services

None of the teams promote to the target community, this combined with the lack of knowledge of the demographic makeup of the local community could lead to not identifying necessary resources to ensure equal accessibility in respect of need for translated promotional material/information etc.

7.4.8 Barriers to accessing services

One respondent felt there were no barriers to accessing services and one actually felt that the target community were actually making their own barriers. Another felt that the team were the barrier due to lack of cultural understanding and knowledge and another felt that it was a PCT issue in that there was not enough investment in staff in this specific area. Services need to be aware that language barriers, lack of knowledge and information of services and cultural differences can affect access and cause barriers if not identified and managed accordingly. The effect of lack of cultural understanding is also likely to impact on effective service delivery.

7.4.9 Gaps in service provision

None of the services were able to evidence how they identified gaps in service provision apart from through SEPIA. One of the respondents identified lack of BME service users as a gap and the only other gaps were around clinical interventions. Identification of gaps is crucial for information for service improvement and delivery. It was during this particular question that one respondent became fully aware of the fact that the service may not actually be as inclusive as desired. This person later stated that the new awareness could benefit the service development and be used as a business plan to identify and request resources.

7.4.10 Equality and Diversity leads

Two respondents have Diversity and Equality leads in their service and two thought that there was a person in the PCT in this role. The research team feel this is not
sufficient, particularly when one respondent claims there is no need for this. It came to light that some of the respondents feel that the Community Development Workers (BME) should be doing this for the whole PCT and that there was a lack of understanding and clarity of what the role is. An organisation with intent to deliver equal and accessible services to the BME community must achieve an approach that is organisation wide with the necessary resources in place.

7.4.11 Race Equality training

Five of the respondents said some of their team had attended race equality training but one went as far to say that it does not identify a need, so no one took up the offered training. It was identified that six of the seven respondents felt the training was important. The seventh respondent did not see the need of the training as team members had come from cities so were well versed in culture and ethnicity.

7.4.12 Future development plans for the services

Three of the services interviewed had future development plans to achieve a responsive and effective service for the BME populations in the area, particularly the eastern European community. One of these was training, one to bring developments in through their business plan and the final one wants to create an action plan and identify someone to take it forward. The other four services have no plans to develop their services in this area. The lack of knowledge and information about the target community and BME communities in general would cause a feeling that this may not be a priority but where when armed with accurate statistics and information there may possibly be a need to make this so.

7.4.13 Individual future development plans

Only one of the respondents has plans for their own future development and that was to promote in primary care. This came about as the respondent gained awareness during and throughout the interview.

7.4.14 Resources and support to address future development

Four of the respondents were able to identify resources and support that would address their future development for the BME communities. These were translated leaflets, translated information on web sites, training and an Equality and Diversity team within the Trust. The project feels the latter would be a very good start and the other resources would come from such a team. The other three were unable to identify resources but one was able to demonstrate how they would request them. One felt that they had all the resources they need and the other felt that because of the small BME population in the area that could not identify resources.

7.4.15 Respondents wish lists

The wish lists from the respondents had some very good ideas and would all help to provide appropriate and effective services for BME service users. Training, research, interpretation services and an identified worker to gain access with the target populations are all resources that could be put in place by an organisation and they would help them achieve what is needed for our BME communities.
8. RECOMMENDATIONS

This section of the report will state the recommendations from the project and link them to three of the themes identified within the DRE national programme. These recommendations have been developed with caution bearing in mind the low response rate that affects the extent to which the findings of this study can be generalised:

Better collection and more effective use of information to access and target service developments:

- There is a need for the BME communities in Dorset to be accurately mapped and the information made available for a wide range of services and for this to be updated regularly. This will allow services to identify need in their community based upon the number of the target population resident there, but this can only be successful if better and more accurate recording of ethnicity is achieved allowing identification of individual ethnic groups, ie. Polish, Slovakian rather than the broader category ‘white European’.

- Further research is required on the target community to ensure the appropriateness of assessment tools and then to develop and use an established tool across target communities that takes account of cultural differences. This research needs to identify the specific mental health needs of the Eastern European community more in depth than has been achieved in this study. Community Development Workers employed by the local Primary Care Trust would be in a position to carry out this study.

- As all services are all reliant on GP referrals, research into the referral pathways from GP’s to CMHT’s needs to be carried out and the findings acted upon. There is also a need to research the GP experience for the target group in order to create more satisfaction for the target community. Again the local Primary Care Trust Community Development Workers would be ideally positioned for this.

The development of more appropriate and responsive services for the Black and Minority Ethnic communities by statutory service providers:

- Each service and the organisation as a whole needs to develop a future strategy for developing and ensuring responsive and appropriate service for people from BME communities taking account of the local demographics and cultural and faith differences.

- Mental health services need to promote themselves, especially the self referral pathway, to the target population where they gather as a community in a way that is understandable and acceptable to BME communities. Translated leaflets and information must be made available if the services wish to offer an inclusive and accessible service. These need to be displayed and available in a number of health and community settings. There is also a need to ensure translation services are accurate and appropriate.
• All services need to adopt a formal method of identifying gaps within service provision, particularly gaps that impact on smaller communities such as BME.

• All individual services need a lead for Equality and Diversity. There also needs to be an organisational lead and structures in place to enable gathering and sharing of information, training etc.

• All individual staff should attend effective Equality and Diversity training. This could be introduced as part of the mandatory training requirement as with other organisations such as Rethink.

• Services need to prepare and gather quality resources for the target community as it is known to be the biggest and still growing BME community in the area. These would need to include quick access to quality translators and accurately translated leaflets and general mental health information relevant to the local area. Other similar areas, such as Somerset could be used to share information and become a resource.

• Cultural information training for GP’s would be an effective way of helping GP services deal with the cultural differences. To be truly effective, this will need developing and delivering with full participation and contribution from people from the local BME communities.

Community Engagement to engage communities in service development and delivery:

• A support worker to help people understand the systems used by this country and its services is essential. Preferably this would be someone of Eastern European descent or at least someone who is well versed in the cultural differences between the native English and Eastern European cultures. There is a need for a telephone support service that can deal with different languages. A community centre for the BME community is necessary so services can promote to and access the BME community.

• Services need an awareness of the stigma towards mental illness in Eastern Europe. This stigma may travel with the people that come to this country and prevent them from seeking help.

• A multi disciplinary approach needs to taken to tackle racism and to tackle the negative perceptions among the indigenous population regarding immigrant workers in Dorset.
10. APPENDICES

1. Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>Weymouth and Portland</th>
<th>West Dorset</th>
<th>North Dorset</th>
<th>Dorset</th>
<th>England</th>
</tr>
</thead>
<tbody>
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<td>96.7</td>
<td>96.6</td>
<td>96.8</td>
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<td>0.5</td>
<td>0.6</td>
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</tr>
<tr>
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<td>1.4</td>
<td>1.5</td>
<td>1.4</td>
<td>2.7</td>
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<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td>1.3</td>
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<td>0.2</td>
<td>0.4</td>
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<td>0.1</td>
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<tr>
<td>Chinese</td>
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<td>0.4</td>
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Statistics for Weymouth and Portland, West and North Dorset, taken from Dorset For You website

http://www.dorsetforyou.com/index.jsp?articleid=344863


<table>
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<th>Area</th>
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<tr>
<td>North Dorset</td>
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<td>66,700</td>
</tr>
<tr>
<td>West Dorset</td>
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<td>96,200</td>
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<td>Weymouth &amp; Portland</td>
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<td>DCC Dorset</td>
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<td>South West</td>
<td>5,086,700</td>
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<td>England &amp; Wales</td>
<td>53,419,200</td>
<td>53,728,800</td>
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Statistics for Weymouth and Portland, West and North Dorset, taken from Dorset For You website

http://www.dorsetforyou.com/index.jsp?articleid=34486

23 Office of National Statistics
24 Office of National Statistics
### 3. Total Population

<table>
<thead>
<tr>
<th></th>
<th>Weymouth and Portland</th>
<th>West Dorset</th>
<th>North Dorset</th>
<th>Dorset</th>
<th>England</th>
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<tbody>
<tr>
<td>Persons</td>
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<td>92,350</td>
<td>61,895</td>
<td>390,980</td>
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<tr>
<td>Males</td>
<td>31,268</td>
<td>44,071</td>
<td>30,818</td>
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<td>Females</td>
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<td>48,279</td>
<td>31,077</td>
<td>202,200</td>
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<td>Percentage change since 1991</td>
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<td>8.1</td>
<td>18.8</td>
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<tr>
<td>Population density (persons per hectare)</td>
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<td>0.9</td>
<td>1.0</td>
<td>1.5</td>
<td>3.8</td>
</tr>
</tbody>
</table>

Statistics for Weymouth and Portland, West and North Dorset, taken from Dorset For You website<sup>25</sup>

http://www.dorsetforyou.com/index.jsp?articleid=344863

<sup>25</sup> Office of National Statistics
4. UCLAN Ethics proforma:

**University of Central Lancashire, Centre for Ethnicity and Health Ethics Proforma**

**Section 1:**

<table>
<thead>
<tr>
<th>Name of Group</th>
<th>Rethink West Dorset Services</th>
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<tr>
<td>Address</td>
<td>Community Resource Team</td>
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<tr>
<td></td>
<td>5 Carlton Road North</td>
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<td></td>
<td>Weymouth</td>
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<td></td>
<td>Dorset DT4 7PX</td>
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<table>
<thead>
<tr>
<th>Name of Support Worker</th>
<th>Joanna Hicks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
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**Section 2:**

**What kind of work does the group intend to do as part of this project?**

The group will conduct a piece of community research to investigate the mental health and well-being needs of adults from the A8 Accession Countries, see below for list of countries, as identified from the Dorset Databook 2007, and identify any barriers that may prevent access to mental health services across North and West Dorset and Weymouth and Portland, which is in the South of the county.

The research will also look at mental health service provider preparedness for the BME community.

It should be noted that the research focus for the group has been narrowed since the initial bid. Members of the Steering Group raised concerns regarding the mental health care needs of the Eastern European migrant workers who are coming to live in the region and it was felt that a focus on Eastern European people would be
How do they intend to do this?

**Structured focus groups will question members of the local A8 Accession Countries community. Semi-structured interview questions have been prepared which will form the basis of the discussions within the focus groups.**

A £10 shopping voucher will be given to respondents who take part in the focus groups, as a gratitude for the time given to the project.

Semi-structured interviews will be held with a lead staff member from each of the local CMHT’s in the target area.

The research team is working closely with the mental health CDW in the region, plus the REL and on-going project by the CDW is tying in with the work of the Rethink team.

Who will the respondents be?

Respondents for the community research will be people of all genders of age 18 – 65, originating from A8 Accession Countries (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia, it has been decided to omit Malta and Cyprus as they are outside of the Eastern European area and data shows there are no residents from the areas). Local networks and agencies will provide details on communities across North and West Dorset and Weymouth and Portland.

Respondents will be approached and recruited through the community links established by the project.

**6 CMHT’s across the target area will be approached through the CMHT lead.**

We are not entirely clear how you are going to
involve the CMHT’s. If you intend to interview CMHT staff as part of the research process or if you are asking CMHT staff to refer possible respondents to you, you will need to get clearance from the Local Research Ethics Committee

Who will they get to do the work?

The Community Engagement Team of 4 will be made up of 2 researchers from our local BME community, a Community Development Worker from Dorset PCT and a project co-ordinator from Weymouth and Portland Rethink.

Where they will undertake the work?

4 focus groups with approximately 8 respondents at each group. 2 of these will take place in the Weymouth area (South), due to the higher number of National Insurance registrations in this area, 1 in the West Dorset area and 1 in North Dorset. The researchers will investigate the most appropriate settings for the focus groups to take place for the community research. These will promote confidentiality but remain comfortable and accessible.

We note that you are planning to carry out the work in a variety of locations. It is important that you visit these settings in advance and that you ensure that they are suitable (i.e. safe; appropriate size; suitably furnished; right degree of privacy and confidentiality; appropriately insured; fire precautions and procedures are in place; staff on hand to help in an emergency; identification of any hazards or risks).

You also need to ensure that you have systems in place to transport any data (e.g. notes etc.) safely and securely back to your main office.

The project coordinator will visit the 6 target area CMHT’s and conduct interviews with one lead member of staff in each team. The need for a confidential setting in which to conduct the interview will be stressed when setting up these appointments.
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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</thead>
<tbody>
<tr>
<td>How will those who are doing the work be supported and supervised?</td>
<td>The team is led by a Rethink team leader and researchers have the full support of Rethink in policy and procedure, including managerial supervision. The team meets regularly. Researchers have taken bank contracts and are employed at £8.12 per hour. Training will be supplied by both UCLAN and Rethink to researchers requirements. The project steering group also supports the researchers, both the UCLAN support worker and CSIP Equality Lead for the South West attend these meetings. The UCLAN support worker meets fortnightly with the team and is available by phone and e-mail.</td>
</tr>
<tr>
<td>How they will ensure that participants in the project have given consent?</td>
<td>An information sheet for the interviews and focus groups has been produced covering all points a-e. (see attached)</td>
</tr>
</tbody>
</table>
**Note 2:** Parental (or responsible adult e.g. teacher if the work is happen in school) consent will be required if any subjects to be interviewed are under 16. Generally speaking, most projects should not be working with under 16’s.

Please enclose the information sheet and confirm that it addresses issues (a), (b), (c), (d) and (e) above

<table>
<thead>
<tr>
<th>Information sheet enclosed ( √ ) tick to confirm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue (a) covered ( √ ) tick to confirm</td>
</tr>
<tr>
<td>Issue (b) covered ( √ ) tick to confirm</td>
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<tr>
<td>Issue (c) covered ( √ ) tick to confirm</td>
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<tr>
<td>Issue (d) covered ( √ ) tick to confirm</td>
</tr>
<tr>
<td>Issue (e) covered ( √ ) tick to confirm</td>
</tr>
</tbody>
</table>

How they will the project ensure confidentiality?

Note: you will not usually need to know (or collect) the names or addresses of respondents.

If you know them already, or if you are going to ask people their names as a matter of courtesy, these should not be recorded on the questionnaires or the notes that relate to the interview.

Note: you cannot guarantee confidentiality to anyone taking part in a focus group. You can request that people keep things within the group,

All data collected either on paper or tape will be securely stored in locked filing cabinets at the Weymouth Rethink office. Only staff working on the project will have access to these. Taped information will recorded on paper and the tapes will be destroyed as soon as recorded on to paper. Tapes will be transcribed by identified staff who will be thoroughly briefed on confidentiality needs of the project.

No personal identifiable information will be recorded about the respondents. Any information and data presented in the final and draft reports will be not be able to be used to identify any persons involved in the project.

Participants will be given the telephone number and e-mail address of the co-ordinator so that they may contact him to receive feedback and report copies.
but you cannot guarantee that the will. This must be made clear to people who agree to participate in focus groups.

**Interview scripts and tapes from the CMHT interviews will be destroyed once the report has been accepted.**

Preliminary discussions with CMHT managers have shown that the respondents are happy to be transparent and do not require strict confidentiality and anonymity. However, should the pilot uncover more sensitive topics that may require confidentiality, this will be reviewed, and respondents will be given the option of anonymity and confidentiality.

| How will data generated by the project be handled and stored? |
| Interview notes and tapes from both parts of the research will be securely stored in a locked filing cabinet in the Rethink Weymouth office. Only staff working on the project will access to it. |

| What risks are there? How will risks be identified and managed? |
| Note you need to think about risks to researcher and volunteers and risks to participants. For some people, simply taking part in the research may be a risk (e.g. if the parent of a young Muslim woman finds out that she has been talking to someone about drugs). For others, particular situations may be risky (e.g. if you are using ex-drug users to work on the project, are you putting them at risk of relapse by asking them to go back into situations where drugs are being sold or used? If something gets stolen from an office, will they get blamed for it [regardless of whether or |

**Interview scripts**: Contact will be made by the coordinator with lead staff at the 6 CMHT’s. Confidentiality will be stressed at this point. The coordinator will travel to each CMHT and interview the lead. It will be made clear that the information given will only be used for the project and the report produced by it and will not be shared/given with any other organisation and the media.

**Focus groups**:  

**Venues**: all venues will be risk assessed and suitability will be thoroughly checked. The Bridport venue will be the Rethink service, other venues will be community buildings.

**Managing anger/violence/distress from respondents**: if distress/agitation is shown by respondents during focus groups, researchers have been instructed not to continue with the group. Researchers will have had instruction on interview technique and body language including non-verbal communication. There will be 2 researchers at each focus group and either the project co-ordinator or the Dorset PCT Community Development Worker will be
not they did it] because everyone knows they are a drug user?). Are the interviewees particularly vulnerable or frail? Are interviewers likely to be vulnerable to allegations of misconduct?

Are the risks of carrying out or participating in individual interviews different from those of taking part or running a focus group? They probably are, and you need to show that you have thought about and addressed this.

**This is one of the most important sections of the form. You must think carefully about what the possible risks are and about what steps can be taken to reduce and manage them. The ethics committee understands that it is usually impossible to eradicate every risk, but the ethics committee must be satisfied that any risks are reasonable, and that steps have been taken to minimise them.**

It may not be necessary attending for support for the researchers.

**Managing confidentiality:** the project will make it clear that all information passed to the researchers will be treated in a confidential manner but the project cannot guarantee that another respondent will not pass on any information once they have left the focus group.

**Managing confidentiality exceptions:** the information sheet that will be seen by all respondents and is also used for consent, will give details of when the project has the right to break confidentiality. This will be only in cases where a respondent has said something that denotes that themselves or someone else would be at risk of serious harm which includes child abuse.
for every researcher to be police (CRB) cleared, but it will be necessary where interviewers are going to interview young (under 16’s) or vulnerable (e.g. elderly, mental health or drug service users) groups unless such interviews are going to take place in an environment where the interviewers are appropriately supervised. The fact that a potential interviewer has a conviction should not automatically bar them from taking part in the research as an interviewer, but it may mean that they need additional supervision or that they should not be allowed to carry out interviews with certain groups of people – it will depend on the nature and seriousness of the conviction.

Although not necessary, as no respondents will be under the age of 16, all researchers will have been CRB checked by the time of the focus groups in line with Rethink policy.

| Please confirm the make up of the steering group | Project co-ordinator and researchers. Community Development Worker, Dorset PCT. Rethink Services Manager. Locality Manager, Dorset PCT. Public Health Team Manager, Dorset PCT. South West Dorset Multicultural Network Co-ordinator. Head of Community Care Operations East Dorset Adult and Community Services, Dorset County Council. CSIP South West Race Equality Lead. UCLAN Project Support Worker. |
| How often does the Steering Group meet. It needs to meet often enough to both guide the research and keep it on track, and to pick up on any ethical issues that may arise. Generally we | Once per month and extra if required. All also available by telephone and e-mail for extra support. |
think that steering groups should meet at least once every six weeks, with additional meetings to be held at critical points (e.g. to decide upon the research focus; to comment on questionnaire design; to review early fieldwork progress and feedback; to consider early findings; to help shape report; to consider recommendations; to plan dissemination of findings.)

Is the Steering Group clear that is has a responsibility for helping to manage the ethical issues that may arise as a result of running this project?

Yes.

Section 3: To Be Completed By UCLan internal ethics committee

Date received:

Reviewed by: Jez Buffin, Kate Davies, Christine Brown

Decision: Approved although:

1. You need to clarify whether you need Local Research Ethics Committee approval.
2. You need to carry out risk assessments on all premises that you propose to use for focus groups to check that they are suitable and safe. You also need to develop a procedure for ensuring that all data is transferred back to the main office as quickly as possible and that data is transported safely and securely. We have amended your consent and information sheets. We require you to accept these changes.
Participant Information Sheet – Focus Group Participants

Research into mental health needs of Eastern European people living and working in North, South and West Dorset

Part 1:

Invitation paragraph.

We would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others if you wish.

Please ask us if there is anything that is not clear or if you like more information.

What is the purpose of the study?

This research project is being carried out to identify the mental health needs of Eastern Europeans that have settled or are working in Dorset. It will also look at if mental health services are prepared to meet the mental health needs of people from Eastern European communities living or working in Dorset. All of the information gathered will be used to write a report that will make recommendations to help mental health services meet the needs of the Eastern European community in Dorset.

Why have been invited to take part?

You have been chosen to take part in this study because you originate from an Eastern European country (A8 Accession Countries Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia but not including Cyprus and Malta), are aged 18-65 and live or work in Dorset and have done so for a minimum of six months and a maximum of ten years.

Do I have to take part?

It is up to you to decide whether to take part in this study. We will describe the study using this information sheet that we will then give to you. We will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving any reason. This will not affect any of your rights. If you withdraw from the study, we will destroy all of your identifiable information, but we will need to use the data collected up to your withdrawal.

What will happen to me if I take part?

We will ask you to attend one focus group at a venue in the area of Dorset that you live near. The focus group will last for approximately one and a half hours and we will
be inviting eight people to each group. Once you have taken part in one focus group we will not ask to see you again. During this focus group we will ask you questions to gather your opinions on mental health in general and questions about how mental health services can meet your needs appropriately. We will ask for your consent to audio record these discussions. All of the audio tapes and any written notes will be stored securely at the research office until the report is written and then it will be transferred to secure storage facilities at the Dorset Primary Care Trust. Nobody apart from the research team will have access to the information that you give us. We will not use any personal information that would identify you in the written report. The study will run until December 2007 and the report should be published in March/April next year, 2008.

Purposive sampling trial.

We will use “purposive sampling” techniques because we need to select people who have useful information in regards to the study we are carrying out. Although this may not be representative of the community as a whole it will be representative of the eastern European community that has settled or is working in Dorset.

Expenses and payments.

If you take part in this study you will be offered travel and childcare costs, you will need to bring receipts with you. You will be also offered a £10 shopping voucher as a gratitude for taking part in the study.

What will I have to do?

To take part in this study you will need to attend one focus group where you will be asked to discuss your thoughts and opinions of mental health issues and how local mental health service provision could meet your needs appropriately. These discussions will be audio recorded, with your consent, and will be used to write a report that will recommend how mental health services can appropriately meet the needs of the Eastern European community in Dorset. You will not be asked to participate in any more parts of the study but you will have the opportunity to attend a presentation of the results and report of the study.

What are the possible disadvantages and risks of taking part?

There are possible risks of taking part due to the nature of the focus group and what will be discussed. We will ask all participants not to discuss what is said during the group outside of it but we cannot guarantee this. We therefore suggest you consider this before disclosing any information during the focus group. If there are comments made that lead the researchers to believe that either you or someone else is at risk of serious harm, including child abuse, we would have to pass this information on to third parties who may include, Dorset County Council, Dorset Primary Care Trust or Dorset Community Safety officers of Dorset Police Force. Another possible risk is of distress caused by the nature of the discussions, which is mental health. The research coordinator is an experienced mental health worker who will be able to offer support as well as inform you of the local accessible services who will be able to assist you in times of distress. If you feel that discussing any of the issues will cause you distress, you do not have discuss these. The study team has full insurance cover with public liability of £10 million, should any injury be caused whilst attending the
focus group. All venues for the groups will have thoroughly risk assessed for comfort, safety and confidentiality.

**What are the possible benefits of taking part?**

We cannot promise the study will help you but the information we get from this study will help mental services in this area to be able to meet the needs of the eastern European community in Dorset more appropriately and effectively.

**What happens if there is a problem?**

Any complaint you have about the way you have been dealt with during this study or any distress you might suffer will be addressed. The detailed information on this is given in Part 2 of this information sheet.

**Will my taking part in the study be kept confidential?**

We will follow ethical practice and all information about you will be handled in confidence. The details are included in Part 2.

If the information in Part 1 has interested you and you are considering taking part, please read the additional information in Part 2 before making any decision.

**Part 2**

**What if I do not want to carry on with the study?**

If you withdraw from the study, we will destroy all of your identifiable samples, but we will need to use the data collected up to your withdrawal.

**What if there is a problem?**

If you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions.

**Complaints.**

If you remain unhappy and wish to complain formally, you can do this through the national Rethink Advice Service (0845 456 0455).

**Harm.**

In the event that something does go wrong and you are harmed during the research and this is due to someone’s negligence then you have grounds for a legal action for compensation against Rethink but you may have to pay your legal costs.

**Will my taking part in this study be kept confidential?**

If you join the study, some parts of the data collected will be looked at by authorised persons from the company organising the research (Rethink). All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.
All research participants have the right to check the accuracy of the data held about them and correct any errors. In order to do this research participants must contact the Project Co-ordinator at Rethink (01305 766193).

**What will happen to the results of the study?**

All of the data collected in the study will be published in a formal report and presented at a launch event. All information and data presented in the final report will not be able to be used to identify any persons involved in the project.

Participants will be given the telephone number and email address of the Project Co-ordinator so that they may contact him to receive feedback and report copies.

**Who has reviewed the study?**

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by Dorset Research Ethics Committee.

**Further information and contact details.**

All research participants will have a copy of the information sheet and signed consent form to keep. If participants want further information any aspect of the research, advice on whether to participate, or someone to contact if unhappy with the study, they should contact the Project Co-ordinator at Rethink on:

Telephone 01305 766193
Email [andrew.court@rethink.org](mailto:andrew.court@rethink.org)
Andrew Court
Rethink
5 Carlton Road North
Weymouth
Dorset
DT4 7PX
Consent Form – Focus Group Participants

Research into mental health needs of Eastern European people living or working in North, South and West Dorset.

Andrew Court

Please initial box

1. I confirm that I have read and understood the information sheet dated 29th November 2007 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical and legal rights being affected.

3. I confirm that I give my consent to be audio recorded during the focus group and for my comments from these tapes to be used for the project report.

4. I understand the research project will keep all the information I give confidential unless I give information that leads them to believe that myself or someone else as at risk of serious harm in which case we will pass this information to third parties ie. Dorset County Council, Dorset Primary Care Trust, Community Safety officers.
5. I agree to keep what other people say within the group as confidential and not to discuss it outside of the group.

6. I understand that other people will also be asked to keep what is said within the group as confidential and not to talk about it outside of the group, but there is no guarantee that they will

7. I am aware that I will be asked to complete a questionnaire that will include questions about my age, gender, ethnicity. This is voluntary.

8. I agree to take part in this study.

---------------------------  ---------------------------  ---------------------------
Name of focus group participant    Date    Signature

---------------------------  ---------------------------  ---------------------------
Name of person taking consent    Date    Signature

When completed: 1 for participant, 1 for researcher file (original)
7. Focus group topic guide:

Research into mental health needs of Eastern European people living in Dorset

Community Focus Group Script

A. Introductions and setting the scene

NB This section includes appropriate openers to discuss when focus group members are arriving and making themselves comfortable and acquainted with the researchers. Ensure the core questions sheet is completed by each of the focus group members at this stage.

- Length of stay in the UK
- Reasons for coming to the UK
- Expectations of living in the UK
- Have expectations been met?/reality of living in the UK
- Family and friends in UK/social networks
- Accommodation and employment

B. Life changes

NB Prompts are based on the seven grief (losses) model. Explain to the focus group that there have been some findings in recent research that indicate a number of changes/losses people experience when they migrate that may lead to people’s mental well-being being affected.
Possible discussion methods may include displaying the 7 grieves (losses) as key words to draw out conversation around those that are pertinent to the group members.

- Family and friends
- Language
- Culture
- Homeland
- Loss of status
- Loss of contact with ethnic group
- Exposure to physical risk

Additional prompts may include:

- Community
- Fear
- Stigma and discrimination
- Racism

Aspects that have affected individuals mental health and well-being the most may be drawn out at this stage.

C. Health

NB To set the scene around mental health a case study example of a fictitious person (s) could be used here to set the scene and provide some incite and clarification of mental health - to provide a distinction between every day emotions and clinical conditions. Key words may be displayed - draw on terminology used by the group members

- Clarification of mental health
- Stigma and discrimination
- Awareness of mental health services
  Best ways to receive information on conditions and services
Place of worship
Public libraries
Doctors
Schools
Hospitals
Community groups
Community/religious leaders
Internet
Employer

- Access to mental health services

NB  Allow group to share experiences between each other and cultures.

Also prompt here for barriers to access:

Language
Trust
Lack of information/knowledge of who to go to
Culture
Stigma/discrimination
Lack of support from families/communities/authorities

- Comparisons with home country
- Suggestions for improvements of services

D. Opportunity for additional discussion
NB Provide the opportunity for group members to add anything further to the discussion that they feel important

E. Exit

NB thank group members for their time and support. Ensure details have been exchanged for individuals to receive further information and publications of reports. Offer any further support and contact details if appropriate.

This is maybe a useful time to ask group members on their future intentions in the UK.

Close.
Research into mental health needs of Eastern European people living in Dorset

WEST DORSET RETHINK BME CEP
SERVICE PROVIDERS INTERVIEW SCRIPT

Introduction
The piece of research that Rethink West Dorset Services are undertaking is one of forty Community Engagement Projects being conducted across England during 2007, and is closely allied to the governments “Delivering Race Equality in Mental Health Care” agenda. The main objectives of the research are to examine the mental health needs of east European communities, originating from accession countries, living or working in Dorset; to establish appropriateness of local mental health service provision for east European communities in Dorset; and to inform any need for local mental health service improvement.

Background/overview
1. Can you explain the main responsibilities of your role and the organisation and team you work in?

2. Can you give an overview of the mental health services you provide?

   (If the interviewee has provided detail on this in question 1 go to question 3. If limited information is provided in question 1, probe for more detail).

3. How does your service promote its mental health services?

4. What are the referral pathways and procedures to your service?
As noted in the introductions this piece of research is specifically investigating the mental health needs of the east European community in Dorset and so the following questions are detailed around this.

**Delivering Race Equality and local service provision**

5. How much knowledge of the Delivering Race Equality in Mental Health Care agenda do you have?

6. How much knowledge do you have about the demographics of the local BME communities in this area?

7. Are you aware of any specific mental health needs of the local Eastern European community?

8. Does your service record the ethnicity of people using your service?
   - Yes
   - No
   - Don't know

9. Can you use this information to identify individual ethnic groups such as Polish, Romanian etc.
   - Yes
   - No
   - Don't know

10. a. How useful is this data to your team and to you as an individual?
    Prompt: where does it go, is it analysed etc
    - b. How important do you think this data is?
      Prompt: the value the interviewee places on collecting such data

11. Within the last six months, approx how many Eastern Europeans have used your service?
12. What percentage of your overall client group does this signify?

13. What services and resources do you currently have available for the Eastern European community? Prompt: i.e. translated materials

14. What additional resources do you feel would benefit the Eastern European community?

15. Do you have any tools in place to assess the mental health needs of the Eastern European community?
   Yes
   No
   Don't know

16. How effective and inclusive do you believe your referral pathways to be for the Eastern European community?

17. How does your service promote its Mental Health services to the Eastern European community?

18. Are there any barriers to overcome that could help you improve on this promotion?
   Prompt: knowledge, tools/methods, budgets/resources

19. Do you have any means of identifying gaps in your current service provision?
   If yes, how have you identified these gaps? Go to question 20.
   If no, is there any reason for this? Go to question 21.

20. What are the gaps you have identified in your current service provision and what effect do these have on people from the Eastern European community?

21. In your opinion, do you believe there are any [other] gaps in your service provision and if so, what are they?
Delivering Race Equality Support Structures

22. Have you a person that is responsible for Equality and Diversity in your team?
   Yes
   No
   Don't know

If no, go to question 23, if yes, go to question 24.

23. If not, is there someone responsible for this in your organisation?
   Yes
   No
   Don't know

24. Have you/your team received any race equality training?
   Yes
   No
   Don't know

25. How important is this training to you?

26. Have you any plans for personal development in the area of Equality and Diversity?

Delivering Race Equality future plans

27. Have you any future development plans that will ensure a responsive and appropriate service for people from ethnic minority communities such as Eastern Europeans etc.?

If yes go to question 28. If no go to question 29.

28. What are your future development plans to ensure a responsive and appropriate service; will they address any gaps that you have identified?

29. What support and resources do you need to address for future development of your services to ensure they are responsive and appropriate?
30. If you had a wish list what 3 things would you like to change about the way your organisation delivers mental health services to BME individuals?

31. Is there anything you would like to add to the discussion?
9. Racially motivated email 1 from a Residents Association

Dear (names)

Thank you for the two posters recently received, one in English, the other not, inviting people to come and talk to your researchers for one and a half hours. They have been displayed as requested.

However, I have to tell you that the committee of our Association was completely disgusted at the sheer waste of money this research represents.

1. We have been approached as "consultees" enough times to know that these "consultations" are undertaken, more often than not, simply to fulfil the requirement to consult, with no real account being taken of the consultees' comments.

2. Why is it necessary to talk to people for one and a half hours to find out what they think, and why is it necessary to provide travel costs, refreshments, and child care?

3. Why is this survey so clearly aimed at our Eastern European friends, who have not helped to pay for our NHS, and who have, in any case, come to our country because they see it as a better place to be than theirs?

4. When one considers how much HMG is interfering in the administration of our healthcare, mainly to its detriment, we feel that any money available should be spent on basic and obvious improvements to the service (such as ridding Dorchester Hospital of MRSA) not on expensive and ineffectual "research" of this nature. (Consider how here in Sturminster Newton we have a very good central GP service with which the vast majority of patients are entirely happy: yet HMG is apparently going to force the practice to change its hours. So much for "consultation.")

5. The emphasis of these posters is offensively for incoming foreigners - one gets the strong impression that the views of the established British people are neither sought nor welcome - even to the extent that while eight Eastern European flags are depicted, nowhere do we see the flag of our own, the host, country!

Yours sincerely

(name)
10. Racially motivated e-mail 2.

Hello (name),

I have just received your letter with reference to whether or not the nation health service meets my requirements. It was addressed to the boxing club that I run.

Firstly is this invitation open to all UK residents who have lived or worked in Dorset or only to our foreign friends who have recently invaded our country.

Secondly I did not notice any of the British flags at the top of the page.

Thirdly what are your limits on travel costs and child care as I have a colleague who has worked for me in Dorset in the last couple of months (She is African) but has recently moved up to Shrewsbury but I have spoken to her about the invitation and she said that she would be interested in attending. She said she would be happy to catch the train down to Dorset and then get a taxi to your location, I am happy to put her up over night at your normal B & B costs of £25.00 and she will get the train back the next day. (she is currently checking on the rail costs). Her regular child minder is also happy to look after her 2 year old for the two days at a cost of £45.00 per day. Please could you let me know the dates and locations of these meetings by return so I can arrange for her to come down.

With the National Health Service struggling as it is wouldn't this money be better spent in the national Health and not on giving our foreign friends the opportunity to moan or indeed praise the services we supply to them free of charge before they have made any significant financial input to this service themselves.

Please respond.

Regards

(name)

P.S

Please do not take this as if I am a racist, it just makes me angry when so much money is spent for non tax/national insurance paying non UK residents when I am trying to get money for a building new or old to improve the boxing facilities for the youngsters (of all nationalities) of North Dorset.

11. Link to article in Dorset Evening Echo and associated comments.

http://www.dorsetecho.co.uk/search/display.var.1933560.0.appeal_for_immigrants_to_help_health_service.php#comments
11. BIBLIOGRAPHY


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O’Donnell CA, Higgins M, Chauhan R, and Mullen K (2007) “They think we’re ok and we know we’re no”. A qualitative study of asylum seekers’ access, knowledge and views to healthcare in the UK. BMC Health Services Research 2007, 7:75


Middlesex University, Research Centre for Transcultural Studies in Health - cited in O’Donnell CA, Higgins M, Chauhan R, and Mullen K (2007) “They think we’re ok and we know we’re no”. A qualitative study of asylum seekers’ access, knowledge and views to healthcare in the UK. BMC Health Services Research 2007, 7:75


Working together to help everyone affected by severe mental illness recover a better quality of life

For further information on Rethink
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Email info@rethink.org
www.rethink.org
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